(17)

No. 08-1515

Supreme Court, U.S.
FILED
AUG 24 2009
OFFICE OF THE CLERK

In The Supreme Court of the United States

GOLDEN GATE RESTAURANT ASSOCIATION,

Petitioner,

v.

CITY AND COUNTY OF SAN FRANCISCO,

Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION ("SEIU"), LOCAL 1021; SEIU UNITED HEALTHCARE WORKERS-WEST; and UNITE HERE! LOCAL 2,

Intervenors/Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR RESPONDENT IN OPPOSITION

PAUL R.Q. WOLFSON
WILMER CUTLER PICKERING HALE AND DORR LLP
1875 Pennsylvania Avenue, NW
Washington, D.C. 20006
Telephone: (202) 663-6390
Facsimile: (202) 663-6363

DENNIS J. HERRERA
City Attorney
WAYNE SNODGRASS
VINCE CHHABRIA
Counsel of Record
CHRISTINE VAN AKEN
Deputy City Attorneys
City Hall, Room 234
One Dr. Carlton B. Goodlett Place
San Francisco, CA 94102
Telephone: (415) 554-4674
Facsimile: (415) 554-4747

Attorneys for Respondent

COCKLE LAW BRIEF PRINTING CO (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTION PRESENTED

San Francisco's universal health care ordinance contains two interlocking components: a comprehensive public health care program available to all uninsured residents at sliding scale fees, and a general health care spending requirement for medium and large employers. Employers may comply with the spending requirement either through their own health care plans, or by paying into the public program. If employers choose the public option, their employees receive a substantial discount on the health care services available through that program. The question presented is:

Does ERISA preempt the portion of San Francisco's universal health care ordinance that imposes a general health care expenditure requirement on medium and large employers, where every employer may readily comply without adopting an ERISA plan or altering an existing plan, and where the option of paying into the public program is a rational choice for employers rather than a penalty?

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iv
STATEMENT	1
A. The Health Care Security Ordinance	1
B. Procedural History	6
ARGUMENT	8
I. THERE IS NO CONFLICT WITH THE FOURTH CIRCUIT	11
II. THERE IS NO CIRCUIT CONFLICT ON WHETHER PAYMENTS TO THE CITY INVOLVE THE CREATION OF AN ERISA PLAN	18
III. THE DECISION BELOW IS CONSISTENT WITH THIS COURT'S ERISA PREEMPTION RULINGS	24
IV. NUMEROUS OTHER FACTORS COUNSEL AGAINST A GRANT OF CERTIORARI	31
A. Petitioner Greatly Exaggerates The Impact Of The Ninth Circuit's Ruling	31
B. The Case Is A Poor Vehicle For Consideration Of Most Arguments Made By Petitioner And Its Allies	35
C. The Result Sought By Petitioner And Its Allies Would Have A Devastating Impact On The People Of San Francisco	37

TABLE OF CONTENTS – Continued

Page

D. The Potential Enactment Of Federal Health Care Legislation Counsels Against A Grant Of Certiorari..... 39

CONCLUSION..... 40

APPENDIX

APPENDIX A Joint Response to Application for Order Staying Mandate and Vacating Stay of District Court Judgment.....App. 1

APPENDIX B Department of Public Health Regulations Implementing Healthy San Francisco and Medical Reimbursement Account Provisions of the San Francisco Health Care Security Ordinance .....App. 43

APPENDIX C Excerpts from San Francisco's Memorandum in Opposition to GGRA's Motion for Summary Judgment in the U.S. District Court .....App. 59

APPENDIX D Findings to San Francisco Health Care Security Ordinance No. 218-06 ..App. 64

TABLE OF AUTHORITIES

Page

FEDERAL CASES

Brundage-Peterson v. Compcare Health Servs. Ins. Corp., 877 F.2d 509 (7th Cir. 1989) 19

Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., 519 U.S. 316 (1997).....12, 25, 27, 30, 35

De Buono v. NYSA-ILA Med. & Clinical Services Fund, 520 U.S. 806 (1997).....12

District of Columbia v. Greater Wash. Bd. of Trade, 506 U.S. 125 (1992) 28

Egelhoff v. Egelhoff, 532 U.S. 141 (2001)...12, 28, 29, 30

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987).....24, 25, 27

Golden Gate Rest. Ass'n v. City & County of San Francisco, 512 F.3d 1112 (9th Cir. 2008) 7

Keystone Chapter, Associated Builders & Contractors v. Foley, 37 F.3d 945 (3d Cir. 1994) 11

Local Union 598 v. J.A. Jones Constr. Co., 846 F.2d 1213 (9th Cir.), *summarily aff'd*, 488 U.S. 881 (1988).....30, 31

Massachusetts v. Morash, 490 U.S. 107 (1989).....19, 20, 25, 27

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).....26

N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).....*passim*

TABLE OF AUTHORITIES – Continued

Page

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) 20

Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007) ..... *passim*

Retail Indus. Leaders Ass'n v. Suffolk County, 497 F. Supp. 2d 403 (E.D.N.Y. 2007) 32

Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) 11

Standard Oil v. Agsalud, 633 F.2d 760 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981) 12, 26

WSB Elec., Inc. v. Curry, 88 F.3d 788 (9th Cir. 1996) 11

FEDERAL STATUTES

29 U.S.C.

§ 223(c)(1) 16

§ 1001(b) 20

§ 1002(1) 19, 20

§ 1002(1)(B) 24

§ 1132(a)(2) 21

§ 1132(a)(3) 21

§ 1144(b)(2)(A) 26

TABLE OF AUTHORITIES – Continued

Page

STATE STATUTES & CODES

114.5 Mass. Code
Regs. 16.01-.05 33

2006 Mass. Legis. Serv. Ch. 58 (West) 33

2009 Conn. Legis. Serv.
Pub. Act No. 09-148 (West) 33

N.Y.C. Admin. Code
§ 22-506 33

Vt. Stat. Ann. tit. 21, § 2003 (2009) 33

SAN FRANCISCO STATUTES, CODES & ORDINANCES

S.F., Cal. Admin. Code
§ 14.1(b)(7) 4
§ 14.1(b)(8) 2
§ 14.2(a) 1
§ 14.2(f) 2
§ 14.2(g) 4

SAN FRANCISCO REGULATIONS

Department of Public Health
Reg. 7(f) 4
Reg. 7(g)(i) 4

Office of Labor Standards Enforcement
Reg. 5.2(A)(1) 3
Reg. 6.2(B)(1) 4
Reg. 6.2(B)(2) 5

TABLE OF AUTHORITIES – Continued

Page

Reg. 7.2(A)(5) 3
Reg. 7.3 5

ARTICLES

Bob Egelko, *Obama administration mum on S.F. health plan,* S.F. Chron., July 20, 2009, at C1 23

Victoria Craig Bunce et al., *Health Insurance Mandates in the States,* Council for Affordable Health Insurance (2008 ed.) at 1 26

OTHER REFERENCES

A.B. 1966, 213th Leg. (N.J. 2008) 32
A.B. 860, 97th Leg., 2005-06 Sess. (Wis. 2005) 32
H.B. 1703, 159th Sess., 2d Year (N.H. 2006) 32
H.B. 2517, 59th Leg., 2d Sess. (Wash. 2005) 32
H.B. 258, 2006 Sess. (Va. 2006) 32
H.B. 4024, 77th Leg., 2d Sess. (W. Va. 2006) 32
H.R. 1316, 2d Reg. Sess. (Colo. 2006) 32
S. 1618, 107th Reg. Sess. (Fla. 2006) 32
S.B. 2684, 2006 Reg. Sess. (Miss. 2006) 32
S.B. 87, 94th Leg., 1st Reg. Sess. (Mich. 2007) 32

STATEMENT

A. The Health Care Security Ordinance

In 2006, San Francisco was in the midst of a health care crisis. An estimated 82,000 people were without coverage. *See* Resp. App. 11. Tens of thousands more only had coverage under bare-bones "safety-net" programs, such as Medicaid, that provided limited care to indigent residents. *Id.* Not only did this threaten the health and well-being of many San Francisco residents; it put tremendous strain on the taxpayers, who were forced to bear the cost when the uninsured used public hospital emergency rooms for preventable illness or injury. *Id.* at 28.

To address this crisis, San Francisco's Board of Supervisors enacted the Health Care Security Ordinance ("HCSO" or "ordinance"). The ordinance has two interlocking components – a public health care program, and an employer health care spending requirement.

The public program is operated by the City's Department of Public Health ("DPH"). Its primary feature is the Health Access Program ("HAP"), which delivers health care to participants from a network of public and private providers. Pet. App. 113a (S.F., Cal., Admin. Code § 14.2(a) (2007)).[1] The HAP assigns

---

[1] The City has changed the name of the program from the HAP to "Healthy San Francisco." For purposes of litigation, the parties have continued to use the name contained in the ordinance.

a primary care physician, nurse practitioner or physician assistant to each participant. Among the specific services provided are preventive care, inpatient and outpatient hospital services, diagnostic and laboratory services, radiological services, mental health services, home health care, and prescription drug benefits. Pet. App. 114a (Admin. Code § 14.2(f)). The value of this care is substantial – DPH estimated that in 2008 it cost the City an average of $261 per participant per month to provide. Resp. App. 13.

The HAP is funded primarily by City tax dollars and partly by employer payments. It is available to uninsured San Francisco residents, regardless of whether they are employed. Enrollees must pay quarterly participation fees on a sliding scale, and must make co-payments for medical visits.

The other component of the ordinance is a mandate that medium and large businesses make minimum health expenditures on behalf of employees who work more than a specified number of hours. Specifically, in 2009, private employers with 20-99 employees, and nonprofit employers with 50 or more employees, must spend $1.23 per hour on behalf of any employee who has been employed for 90 days and works more than eight hours per week. Private employers with 100 or more employees must spend $1.85 per hour for each such employee. The requirement is capped at 40 hours per week. Pet. App. 111a-12a (Admin. Code § 14.1(b)(8), (10); Pet.

App. 138a (S.F., Cal., Office of Labor Standards Enforcement Reg. 5.2(A)(1)).

According to studies compiled by the San Francisco Controller's Office, roughly 90% of medium and large businesses already provided health insurance to their employees when the ordinance was enacted. Resp. App. 15. And the average monthly insurance premium in California at that time was $379. *Id.*

To comply with the mandate, employers may spend money through their own health care plans, or make payments to the City on behalf of their workers. *Id.* They may also fulfill the expenditure obligation through a combination of methods. For example, an employer may prefer to keep its full-time employees in a private ERISA plan while selecting the public option for its part-time employees.

The program is structured so that, if an employer chooses the city payment option, it need only write a check, and all employees on whose behalf payment is made are eligible to participate in the City's program. Contrary to petitioner's representation, the employer does not "enroll [its] employees with the City." Pet. 10. The employer simply pays the City on behalf of specified workers, and notifies the workers that it has done so. Pet. App. 144a (OLSE Reg. 7.2(A)(5)). The rest (enrollment, the type of care provided,

copayments) is purely between the City and the individual.[2]

Employees who qualify for HAP membership are, if their employers choose to satisfy the spending requirement by paying the City, entitled to enroll in the program at a 75% discount on the quarterly participation fees they would otherwise be required to pay. Resp. App. 53-54 (DPH Reg. 7(f)). As discussed more fully below, the result is that, when an employer pays the City, the employer knows its workers will be eligible for comprehensive care at a far lower cost than what it would have to pay for private insurance.

The City also adopted two regulatory provisions – unmentioned by petitioner – that facilitate compliance for large, multijurisdictional employers. The first may be utilized by employers that provide traditional health insurance to their workers, such as Kaiser or Blue Shield. It allows these employers to establish compliance without keeping track of the health care dollars spent on each individual employee, and without making any separate calculations for their San Francisco employees. Pet. App. 141a (OLSE Reg. 6.2(B)(1)). An employer that purchases

---

[2] Individuals who work in San Francisco but live elsewhere do not qualify for HAP participation, but the City uses employer payments to provide medical reimbursement accounts for such individuals. They may draw from their accounts to obtain reimbursement for medical expenses, including payments of health insurance premiums. Pet. App. 110a, 114a-15a (Admin. Code §§ 14.1(b)(7), 14.2(g)); Resp. App. 55 (DPH Reg. 7(g)(i)).

insurance for its employees in San Francisco and in other parts of the country need only divide its total payments to the insurance company for all those employees by the total number of employees. Assuming the amount per employee is greater than the spending obligation (and private health insurance is far more expensive than the spending obligation), this establishes compliance.

The second regulatory provision allows employers that operate "self-insured" plans (through which the employer bears the risk of employee health care costs on its own rather than paying an insurance company a set rate to bear that risk) to establish compliance in similar fashion. It provides that such employers comply "if the preceding year's average expenditure rate per employee meets or exceeds the applicable expenditure rate . . . for that employer." Pet. App. 141a (OLSE Reg. 6.2(B)(2)). Accordingly, an employer with a self-insured plan may establish compliance simply by showing that it has spent a certain amount per employee on a plan-wide basis.

The medium and large employers subject to the ordinance must also keep records. These records are generally already kept in the normal course of business, and employers are not "required to maintain such records in any particular form." Pet. App. 116a. Once per year, employers must file a one-page report with the City, identifying the total amount paid for health care and the manner in which the money was spent. Pet. App. 144a (OLSE Reg. 7.3).

Since the HCSO became fully operational in January 2008, San Francisco has taken great strides towards the achievement of universal health care. In less than 1½ years, the number of residents without health coverage dropped from 82,000 to fewer than 23,000, and that number continues to go down. Resp. App. 25. Following enactment of the ordinance, emergency room visits at San Francisco General Hospital dropped almost seventy percent in one year – from 29,976 to 8,944. *Id.* at 28.

B. Procedural History

Petitioner filed suit in the Northern District of California, alleging that the Employee Retirement Income Security Act of 1974 ("ERISA") preempts the health care spending requirement. The district court granted summary judgment for petitioner, reasoning that the ordinance was "designed to act immediately upon, and cannot operate successfully without the existence of [ERISA] plans." Pet. App. 93a. At the same time, however, the court rejected petitioner's contention that monetary payments by employers to the City themselves create a "*de facto* ERISA plan." Pet. App. 94a.

The Ninth Circuit granted the City's application for a stay of the district court's ruling. The court ruled that, given the availability of a non-ERISA compliance option for every type of employer (namely, payment to the City), the district court was wrong to conclude that the ordinance acts immediately upon

ERISA plans or interferes with plan uniformity. *Golden Gate Rest. Ass'n v. City & County of San Francisco*, 512 F.3d 1112, 1119-23 (9th Cir. 2008). The court noted that legal requirements like San Francisco's – that "only relate[ ] to ERISA plans at the election of an employer" – are regularly upheld against ERISA preemption challenges. *Id.* at 1122 (quotations omitted). The court also concluded that the balance of hardships tipped in favor of the City, and that the public interest weighed in favor of a stay pending appeal. *Id.* Petitioner filed an application to this Court to lift the Ninth Circuit's stay order, which was denied by the Circuit Justice.

After the parties briefed and argued the case on the merits, the Ninth Circuit reversed the district court. This time, petitioner and its allies focused on the argument that an employer actually creates an ERISA plan when it writes a check to the City, thereby leaving employers with no non-ERISA means for complying with San Francisco's requirement. The Ninth Circuit rejected this argument, determining that the city payment option lacks most *indicia* of an ERISA plan. The court observed that the employer's obligations under the city payment option "do not run the risk of mismanagement of funds or other abuse," which was the original concern that led to ERISA's passage. Pet. App. 20a. It observed that the HAP is a government entitlement program, funded primarily by taxpayer dollars, that is available to residents regardless of employment status. Pet. App. 24a-25a. And the court described the key differences between

the city payment option and an employer's purchase of health insurance from a third party, which does involve the creation of an ERISA plan. *Id.* at 26a.

Petitioner also persisted in the argument that, even if payments to the City do not create an ERISA plan, the spending requirement was preempted because it had an improper "connection with" ERISA plans. The court rejected this argument, explaining that the existence of the city payment option meant no employer was required to adopt an ERISA plan, or to provide specific benefits through an existing ERISA plan. Pet. App. 29a. The court also rejected the argument that the HCSO has a forbidden "reference" to ERISA plans, observing that "[w]here a law is fully functional even in the absence of a single ERISA plan . . . as it is in this case, it does not make an impermissible reference to ERISA plans." Pet. App. 36a.

Petitioner sought en banc rehearing, which was denied. Petitioner then filed an application to this Court for a stay pending a petition for certiorari, which was also denied.

ARGUMENT

The Court of Appeals correctly upheld San Francisco's program, because ERISA does not preempt local requirements that give employers a reasonable option for complying that does not involve the adoption or alteration of an ERISA plan. The

option to pay the City is a reasonable choice for employers, and it does not create an ERISA plan.

The city payment option is reasonable, indeed attractive, because the employers' payments make their workers eligible for comprehensive health services, funded primarily by City tax dollars, for far less than the employers would have to pay for comparable benefits on the private market. As such, this case is clearly distinguishable from *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), which struck down a Maryland law that imposed a bare penalty on Wal-Mart for failing to provide an adequate ERISA plan for its employees.

Nor does the employer create an ERISA plan by exercising the city payment option. This arrangement neither meets the statutory definition of such a plan nor implicates ERISA's central concern – ensuring that benefits promises by private employers to their employees are kept. As the Ninth Circuit explained in detail, writing a check to the City on behalf of specified employees is not remotely analogous to third-party health insurance contracts, which *are* ERISA plans.

At the end of the day, petitioner's argument rests on a faulty premise: that ERISA immunizes employers from being required to spend money in areas, like health care, mentioned in the ERISA statute. As this Court has already explained, ERISA preemption protects only plan uniformity for employers, not general expenditure uniformity.

Because the ordinance in no way interferes with plan uniformity, the Ninth Circuit's ruling that it is not preempted is consistent with this Court's ERISA preemption jurisprudence.

This case is the wrong vehicle, at the wrong time, to consider an employer's claim that ERISA preempts general health care spending requirements. Petitioner presented no evidence that the city payment option is not a rational choice for employers. Nor did it present evidence that the ordinance, even if replicated elsewhere, would impose anything but a *de minimis* administrative obligation on employers. Indeed, the only evidence in the record on these issues contradicts petitioner's claims.

Nor is there any immediate threat that numerous similar laws will sprout up throughout the country, particularly with Congress considering federal health care reform legislation. And the serious possibility that federal legislation will moot the ERISA preemption issue in this case weighs heavily against the Court granting certiorari now. Finally, if federal legislation is not enacted, and if other jurisdictions were then to enact laws similar to San Francisco's in the future, this Court would have the opportunity to address the arguments presented by petitioner and its allies at that time, and on a better record.

I. THERE IS NO CONFLICT WITH THE FOURTH CIRCUIT.

There is widespread agreement that ERISA does not preempt a local requirement if employers have a reasonable non-ERISA means to comply with that requirement. *See, e.g., Keystone Chapter, Associated Builders & Contractors v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994) ("[w]here a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of an employer, it affects employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan") (internal quotations, citations and brackets omitted). *See also Fielder*, 475 F.3d at 193 (state laws that "do not bind the choices of employers or their ERISA plans [are] generally not preempted"); *WSB Elec., Inc. v. Curry*, 88 F.3d 788, 795 (9th Cir. 1996) ("nothing in California's scheme requires the establishment of a separate benefit plan in order to comply with the state law. California's statute does not require public works contractors to modify their benefits plans at all").

The above rule is grounded firmly in this Court's precedents, which make clear that while ERISA preempts laws that dictate employer choices about employee welfare benefit plans, it does not preempt generally applicable laws that merely influence choices with respect to ERISA plans. Thus, ERISA prevents states from dictating *which benefits* must be contained in plans. *See, e.g., Shaw v. Delta Air Lines,*

Inc., 463 U.S. 85, 96-97 (1983) (striking down law that required plans to include pregnancy benefits). It prevents states from forcing employers to *adopt* ERISA plans in the first place. *See, e.g.*, *Standard Oil v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1980), *summarily aff'd*, 454 U.S. 801 (1981) (striking down Hawaii law that required employers to adopt ERISA plans with specified benefits). And it prevents states from dictating *who* must benefit from ERISA plans. *Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) (state law preempted because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status").

In contrast, ERISA does not preempt health care surcharges that exert a strong influence on decisions about ERISA plans. *See N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 659-60 (1995). It does not preempt imposition of a generally applicable tax upon facilities owned by ERISA plans. *De Buono v. NYSA-ILA Med. & Clinical Services Fund*, 520 U.S. 806, 816 & n.16 (1997). And it does not preempt state laws that give powerful incentive to ERISA apprenticeship programs to seek regulatory approval from the state, and to make the changes necessary to obtain such approval, as long as the laws do not force them to do so. *Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 332-33 (1997).

Obviously, if employers may readily comply with a requirement without adopting or altering ERISA plans, such a requirement does not dictate choices

with respect to plans. As set forth below, the Fourth and Ninth Circuits merely applied this well-established principle in the specific context of health care spending, and reached consistent results.

Fielder involved a preemption challenge to Maryland's Fair Share Act, which provided that any Maryland for-profit employer with more than 10,000 employees that does not spend up to 8% of its payroll on health insurance (*i.e.*, Wal-Mart) must make up the deficiency by paying it to the Maryland Secretary of Labor. 475 F.3d at 184. Wal-Mart's employees would not receive any benefits, services, or cost savings in return for such payments. *Id.* at 193.

The Fourth Circuit held that this law effectively required Wal-Mart to alter its ERISA plan because no rational employer would choose to pay the money to the State when the employer could instead increase health care spending in a manner that benefited its employees:

> An employer would gain from increasing the compensation it offers employees through improved retention and performance of present employees and ability to attract more and better new employees. In contrast, an employer would gain nothing in consideration of paying a greater sum of money to the State. Indeed, it might suffer from lower employee morale and increased public condemnation.

> In effect, the only rational choice employers have under the Fair Share Act is to *structure their ERISA healthcare benefit plans* so as to meet the minimum spending threshold. The Act thus falls squarely under *Shaw*'s prohibition of state mandates on *how employers structure their ERISA plans*.

Id. at 193-94 (emphasis added).

As the Ninth Circuit explained, San Francisco's ordinance, "[i]n stark contrast to the Maryland law, . . . offers employers a meaningful alternative that allows them to preserve the existing structure of their ERISA plans." Pet. App. 38a-39a. Workers whose employers comply through payments to the City, rather than by establishing or altering ERISA plans, receive "tangible benefits" in return. *Id.*

Highlighting the reasonableness of the city payment option, almost nine hundred medium and large businesses selected it in the first 1½ years of its existence. Resp. App. 33. That so many employers have selected this option is not surprising, since it allows employers to avoid the inconvenience of setting up their own ERISA plans, while knowing that their workers will receive comprehensive health

coverage from the City at a price far lower than it would cost the employers in the private market.[3]

In short, the option to pay the government in *Fielder* was a penalty that no rational employer would choose. The city payment option here is not a penalty, because it gives employers a meaningful, non-ERISA compliance alternative that allows them to maintain plan uniformity. San Francisco's ordinance, in other words, is utterly indifferent to whether an employer has an ERISA plan. Thus, under the Fourth Circuit's analysis, an ordinance like San Francisco's would survive a preemption challenge. While the Fourth Circuit concluded that Maryland's law "directly regulat[ed] the structuring or administration of an ERISA plan," 475 F.3d at 192, it could not have made the same statement about the HCSO. The two decisions operate in harmony, and they are both consistent with established ERISA precedent from other contexts.

---

[3] The City presented unrebutted evidence in the district court that the health benefits received by employees from the City are extraordinarily generous in relation to the amount paid by the employer, and in comparison to the amount the employer would be required to pay on the private market. The average insurance premium in California was $379 per month when the ordinance took effect. In contrast, for a medium-sized employer with an employee who works 20 hours per week, the employer could satisfy its spending obligation in 2008 by paying the City $ 93.60 per month, even though it would cost the City much more than that to provide the care. In short, the city payment option gives employees a HAP membership that provides comprehensive health services at pennies on the dollar for the employer.

Notwithstanding this, petitioner claims a circuit conflict based on the Fourth Circuit's discussion of an issue that was not presented to, or considered by, the Ninth Circuit. Specifically, after holding that the option of paying the government was nothing more than a penalty that forced Wal-Mart to alter its ERISA plan, the Fourth Circuit turned to Maryland's alternative argument that Wal-Mart had other, private non-ERISA alternatives for complying. According to Maryland, Wal-Mart could satisfy the spending requirement through the creation of on-site medical clinics or Health Savings Accounts. The court rejected this argument on the ground that the purported alternatives were unrealistic. 475 F.3d at 196. And *then* the court observed that even if Wal-Mart could avail itself of these options, they would necessarily also produce a change in the company's ERISA plan:

> If Wal-Mart were to attempt to utilize non-ERISA health spending options to satisfy the Fair Share Act, it would need to coordinate those spending efforts with its existing ERISA plans. For example, an individual would be eligible to establish a Health Savings Account only if he is enrolled in a high deductible [ERISA] health plan. *See* 29 U.S.C. § 223(c)(1). In order for Wal-Mart to make widespread contributions to Health Savings Accounts, it would have to alter its package of ERISA health insurance plans to encourage its employees to enroll in one of its high deductible health plans. From the employer's perspective, the categories of ERISA and non-ERISA healthcare spending

> would not be isolated, unrelated costs. Decisions regarding one would affect the other and thereby violate ERISA's pre-emption provision.

Id. at 196-97. This is not, as petitioner asserts, an alternative holding by the Fourth Circuit that *any* spending mandate in the health care area must be preempted – *i.e.*, that every conceivable non-ERISA compliance option would become entangled with ERISA plans and necessarily interfere with ERISA plan uniformity. It is a rejection of the specific arguments presented by Maryland.[4]

Finally, the implications of a rule preventing local governments from imposing any general health care spending requirement on employers show that the Fourth Circuit could not have intended to adopt such a rule. San Francisco's ordinance goes out of its way to avoid giving employers an incentive to adopt or alter ERISA plans. If, instead, San Francisco imposed a payroll tax on employers to fund a comprehensive public health care program *without regard* to whether employers already have health care plans (that is, without giving employers credit for the health care spending they already make), this

---

[4] Petitioner omits the sentences from the above passage which show that the Fourth Circuit was addressing Maryland's specific argument about the non-ERISA compliance options it offered. As Judge William Fletcher pointed out in his opinion concurring in the denial of rehearing en banc, the eight dissenting judges from the Ninth Circuit did the same thing. Pet. App. 45a-46a.

would create a significant incentive for employers to drop their ERISA plans, to avoid spending substantial sums on health coverage that their employees could instead obtain for free. Nobody could reasonably argue that such a payroll tax would be preempted. It would be ironic, then, if ERISA were held to preempt a law that imposed far fewer incentives with regard to plans. Given the backwards legal regime that would result from the broad rule that petitioner ascribes to *Fielder*, there is no basis for concluding that the Fourth Circuit intended to adopt it.[5]

II. THERE IS NO CIRCUIT CONFLICT ON WHETHER PAYMENTS TO THE CITY INVOLVE THE CREATION OF AN ERISA PLAN.

Petitioner and some *amici* also argue that the Ninth Circuit created a conflict by rejecting the argument that when an employer opts to comply with the HCSO by writing a check to the City, this itself

---

[5] As discussed by the Brief of *Amicus Curiae* Nibbi Bros. Associates, Inc., courts have reached the same conclusion about the many prevailing wage laws that allow employers to comply in part by providing ERISA benefits to their employees. If ERISA preempted prevailing wage laws that gave employers credit for ERISA spending, while leaving undisturbed prevailing wage laws that refused to give credit for ERISA spending, this would incent employers to drop ERISA plans, which is precisely the opposite of what the preemption provision intended. Petitioners seek a result that would disturb the settled understanding among the circuits that prevailing wage laws with benefits components are not preempted.

involves the creation of an ERISA plan. But no other appellate decision even considers whether a public payment option is an ERISA plan. Accordingly, to create the illusion of a conflict, petitioner and its allies rely on cases which hold that an employer creates an ERISA plan when it contracts with a health insurance company to provide health care to its workers. *See, e.g.*, *Brundage-Peterson v. Compcare Health Servs. Ins. Corp.*, 877 F.2d 509, 511 (7th Cir. 1989). They attempt to analogize these insurance contracts to the city payment option, and contend a circuit conflict exists because the Ninth Circuit rejected the analogy. That is not a real conflict. And the Ninth Circuit was right to reject the analogy, which is inapt, is contrary to the purposes of ERISA, and would, if adopted, create serious problems in ERISA preemption law.

ERISA defines an "employee welfare benefit plan" as "any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise," specified benefits. 29 U.S.C. § 1002(1). The specified benefits include, among others, vacation, disability, unemployment, severance, and, of course, medical benefits. *Id.*

In *Massachusetts v. Morash*, 490 U.S. 107 (1989), this Court explained that because the reach of the above definition of an employee welfare benefit plan is – like the preemption provision – potentially limitless, the determination whether a particular

arrangement is the type of "plan" that falls within ERISA's ambit must be made with reference to "'the provisions of the whole law, and to its object and policy.'" *Id.* at 115 (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51 (1987)). Applying this principle, the Court in *Morash* determined that vacation benefits paid out of general assets did not present the types of risks that Congress intended to address when it enacted ERISA and, therefore, that it would not read the statute to encompass such an employer policy to pay vacation benefits. *Id.*

Here, an examination of ERISA's "object and policy" demonstrates why the Ninth Circuit was right to reject petitioner's analogy to an insurance contract. While petitioner and its *amici* paint ERISA as a law whose central purpose is to preserve some undefined "uniformity" for employers, in actuality the statute's "primary concern" is "with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits . . . " *Morash*, 490 U.S. at 115 (internal citations omitted). *See also* 29 U.S.C. § 1001(b). In other words, the primary purpose of ERISA is to ensure that private employers' benefits promises to their employees are kept.

These concerns are clearly implicated by an employer's promise to provide health insurance to its employees, because under this arrangement the employer remains ultimately responsible for "providing" the benefits. 29 U.S.C. § 1002(1). The employer, when negotiating the health insurance contract, gives shape to the plan by deciding, for

example, which treatments will be covered or how claims will be processed. And if the insurance company does not fulfill its contractual obligation to deliver the contemplated benefits to the employees, the employer, as an ERISA fiduciary, can sue the insurer to make sure that the employer's promise to the employees is kept. *See* 29 U.S.C. §§ 1132(a)(2), (3).

As the Ninth Circuit explained, with the city payment option, "[t]he employer never negotiates or signs a contract with the City, and the employer has no control over the City's coverage decisions. When the City administers the HAP, it does not act as the employer's agent entrusted to fulfill the benefits promises the employer made to its employees." Pet. App. 26a. Nor does the employer enroll its employees with the HAP. The mere act of writing a check to the City on behalf of specified employees, and informing those employees that the check has been written, is not remotely comparable to a contractual relationship between an employer and a health insurance company.

And because the Ninth Circuit explained why third party insurance arrangements are ERISA plans even while the city payment option is not, Pet. App. 25a-26a, there is no basis for petitioner's assertion that the decision will cause courts to begin ruling that third-party contracts are not ERISA plans. *See* Pet. 36 ("employers will be able to avoid ERISA's fiduciary duty rules and its civil and criminal enforcement provisions merely by hiring a third-party to perform the bundle of plan-design and

administrative-and-fiduciary tasks inherent in any plan"). If a litigant had the audacity to make such an argument in a future case, the first authority a court would cite to reject it is the Ninth Circuit's decision below.

In fact, had the Ninth Circuit concluded that an employer creates an ERISA plan when it calculates its health care spending obligation and makes payments to the government, *this* would have created major problems in ERISA preemption law. For example, imagine that a local government, instead of adopting a program like San Francisco's, simply imposed a payroll tax to be used to fund a public health program for all persons who work in the jurisdiction. Nobody could reasonably contend that an employer creates an ERISA plan when it pays this payroll tax. Yet petitioner here has advocated a definition of "ERISA plan" that would include this scenario – the employer creates a plan simply by determining its spending obligation and satisfying that obligation by making a payment to the government, which the government then uses to fund a public health program that includes the employer's workers.

Another consequence of deeming the city payment option a "plan" would be that federal obligations (and liabilities) could be imposed on employers with respect to matters over which they have no control, such as the obligations to act as a fiduciary with respect to benefits provided to HAP participants, and to create and operate a system for

processing claims by HAP participants. Equally problematic, San Francisco public health officials who operate this entitlement program could be subjected to ERISA's regulatory regime simply because some employers chose to satisfy their health care spending obligations by writing a check to the City. These consequences underscore the serious flaws in the argument that the city payment option creates an ERISA plan.

Petitioner makes much of an *amicus* brief filed below by the former Secretary of Labor agreeing that the city payment option creates an ERISA plan. More noteworthy, however, is that none of the 28 judges involved in the proceedings below adopted this novel argument – not the district judge who ruled against the City, and not the eight circuit judges who dissented from denial of rehearing en banc. Moreover, the current Department of Labor has stated it is "considering issues in the case," Bob Egelko, *Obama administration mum on S.F. health plan*, S.F. Chron., July 20, 2009, at C1, so it would be wrong to assume that the former Secretary's brief is reflective of the current Administration's views.

Once it is understood that the city payment option does not create an ERISA plan, the language permeating the petition to the effect that the ordinance intrudes on "plan regulation" is revealed to be widely off the mark. *See, e.g.*, Pet. 28 (arguing decision below allows local governments to "regulate ERISA plans themselves by first requiring their establishment and then dictating what benefits the

plan provides . . . "). Such assertions depend on the assumption that the city payment option creates a plan, and the petition unravels when that assumption is removed.

III. THE DECISION BELOW IS CONSISTENT WITH THIS COURT'S ERISA PREEMPTION RULINGS.

At the end of the day, petitioner's preemption argument is based on the assumption that employers are entitled to *expenditure* uniformity in areas mentioned by the ERISA statute. That assumption is wrong – ERISA does not insulate businesses from being required to spend money in these areas. ERISA protects *plan* uniformity for employers, but "cost uniformity was almost certainly not an object of pre-emption . . . " *Travelers*, 514 U.S. at 662.

This is illustrated by *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), which makes clear that states and localities may regulate expenditures on benefits mentioned in ERISA (in that case severance pay), so long as they do not require adoption or alteration of ERISA plans:

> Appellant's basic argument is that any state law pertaining to a type of employee benefit listed in ERISA necessarily regulates an employee benefit plan, and therefore must be pre-empted. Because severance benefits are included in ERISA, *see* 29 U.S.C. § 1002(1)(B), appellant argues that ERISA pre-empts the Maine statute. In effect,

> appellant argues that ERISA forecloses virtually all state legislation regarding employee benefits. This contention fails, however, in light of the plain language of ERISA's pre-emption provision, the underlying purpose of that provision, and the overall objectives of ERISA itself. . . . ERISA's pre-emption provision does not refer to state laws relating to "employee benefits," but to state laws relating to "employee benefit *plans*". . . . The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and a "plan," Congress' choice of language is significant in its pre-emption of only the latter.

482 U.S. at 7-8 (emphasis in original).

Two other cases in which the Court upheld local regulation of benefits mentioned in ERISA were *Dillingham* and *Morash*. In *Dillingham*, the state's regulation of apprenticeship programs created powerful incentives for those programs to alter their conduct, and may have affected employer costs, but that was not sufficient to establish preemption. 519 U.S. at 332. In *Morash*, the state's requirement that employers reimburse employees for unused vacation time obviously affected employers' costs, but there was no preemption in that case because the requirement did not regulate ERISA plans. 490 U.S. at 114-15.

In the area of health care itself, ERISA contemplates that employers will be subject to disparate costs across jurisdictions. If the goal of

ERISA preemption had been health care expenditure uniformity, Congress would not have included the savings clause, which exempts from preemption state laws regulating insurance. 29 U.S.C. § 1144(b)(2)(A). The savings clause has resulted in the enactment of more than 1,961 mandates on health insurance, and no two states impose identical sets of coverage mandates. Victoria Craig Bunce et al., *Health Insurance Mandates in the States*, Council for Affordable Health Insurance (2008 ed.) at 1. Accordingly, the cost of employer-provided health insurance varies dramatically from state to state. *Id.* at 3-5. "Such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985). And that is why "cost uniformity was almost certainly not an object of pre-emption, just as laws with only an indirect economic effect on the relative costs of various health insurance packages in a given State are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA *plans*." *Travelers*, 514 U.S. at 662.[6]

---

[6] Petitioner asserts that the preemption provision was meant to preclude bare health care spending requirements at the state or local level. Pet. 4-5 & n.13. But it does not point to a single word in ERISA's voluminous legislative history to support this conclusion. And although one former Congressional staffer has claimed that the provision was designed in part to preempt the Hawaii health care statute in existence at the time, *id.*, that statute was not a general expenditure requirement; it required that employers actually adopt employee welfare benefit plans. *See Agsalud*, 633 F.2d at 766.

Petitioner also makes much of the possibility that a local requirement in one jurisdiction might affect an employer's decisions about benefit expenditures in other jurisdictions. But the local severance and vacation pay requirements in *Fort Halifax* and *Morash*, the hospital surcharges upheld in *Travelers*, and the apprentice regulations upheld in *Dillingham* may all provide employers with some incentive to decrease spending on benefits in other jurisdictions. These cases demonstrate that ERISA's preemption provision was never intended to provide employers with umbrella protection against laws that might simply change the mix of economic incentives to increase or reduce benefit expenditures.

Petitioner and its allies disregard all of this, and instead rely upon an analytical sleight-of-hand that blurs the distinction between "expenditures" or "benefits" on the one hand, and "plans" on the other. For example, one brief asserts that "[t]he need to monitor *expenditures* in multiple jurisdictions is squarely at odds with ERISA's purpose of establishing a uniform system of *plan* regulation."[7] Similarly, petitioner quotes *Travelers* as saying that the purpose of ERISA preemption is to "'avoid a multiplicity of regulation in order to permit the nationally uniform

---

[7] Brief for the Retail Industry Leaders Association and the Chamber of Commerce of the United States of America as *Amici Curiae* in Support of Petitioner ("RILA") at 14 (emphasis added).

administration' of employee benefits." Pet. 22 (quoting *Travelers*, 514 U.S. at 657). What *Travelers* actually says is that the purpose of ERISA preemption is to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of *employee benefit plans*." *Travelers*, 514 U.S. at 657 (emphasis added).

When the distinction between expenditures and plans is brought back into focus, it becomes clear that there is no conflict with the two decisions primarily relied upon by petitioner and its allies: *Egelhoff* and *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992).

The Washington statute in *Egelhoff* provided that, in the event a couple divorces, and then one member of the couple dies after the divorce, the survivor is not entitled to the benefits of the dead spouse's ERISA plan, even if the plan does not include such a limitation on the rights of the divorced survivor. 532 U.S. at 147. Washington argued the statute was not preempted because it exempted ERISA plans which explicitly provided that divorced spouses should receive plan benefits. Thus, Washington argued, there were two ways plan administrators could comply with the statute: (1) by administering their plans differently in Washington; or (2) by changing the terms of their plans to include specified language. But the Court held this did not save the statute from preemption, because *both* compliance options required plan administrators to

change the way they wrote or administered their plans: "Plan administrators must either [disregard the language of their plans and] follow Washington's beneficiary designation scheme or alter the terms of their plan so as to indicate that they will not follow it." *Id.* at 150.

And it is in this context that the *Egelhoff* Court expressed concern with the need to "maintain a familiarity with the laws of all 50 States." 532 U.S. at 151. If a law forces a plan administrator to *change its ERISA plan* in a given state, that goes to the core of what ERISA's preemption provision guards against – the possibility of plan administrators being forced to "maintain a familiarity with the laws of all 50 States so that they can *update their plans* as necessary to satisfy the opt-out requirements of other, similar statutes." *Id.* at 151 (emphasis added). Under the HCSO, employers must track their health care expenditures, just as they must already keep track of wages and other payroll matters. But they are not forced to change anything in their plans to comply with the ordinance.[8]

---

[8] Similarly, the statement in *Egelhoff* that the "tailoring of plans *and employer conduct* to the peculiarities of the law of each jurisdiction is exactly the burden ERISA seeks to eliminate" does not have the broad meaning petitioner gives it. 532 U.S. at 151 (citation and quotations omitted, emphasis added). ERISA does not protect employers from tailoring their conduct to local requirements with respect to everything; it protects them from tailoring their conduct with respect to plans.

Nor does the decision below conflict with *Greater Washington*. Petitioner argues that both the HCSO and the ordinance struck down in *Greater Washington* make unlawful "reference to" ERISA plans because they involve measuring compliance with reference to an existing ERISA plan. However, as the Court explained in *Dillingham*, a local law makes an unlawful "reference to" an ERISA plan if the law "acts immediately and exclusively upon ERISA plans," or if the "existence of ERISA plans is essential to the law's operation." *Dillingham*, 519 U.S. at 325. That was true of the ordinance in *Greater Washington* because an employer's obligation was triggered *directly by* the benefits it offered through an ERISA plan – whatever ERISA benefits the employer offered, the employer had to provide those same benefits to injured employees on workers' compensation. 506 U.S. at 126-27. If the employer had no ERISA plan, there was no obligation. Here, the HCSO operates on employers "irrespective of the existence of an ERISA plan." *Dillingham*, 519 U.S. at 328 (quotations and ellipses omitted).

Finally, some *amici* attempt to conjure up a conflict with Supreme Court precedent by selectively quoting the language of a Ninth Circuit decision that this Court summarily affirmed: *Local Union 598 v. J.A. Jones Constr. Co.*, 846 F.2d 1213 (9th Cir.), *summarily aff'd*, 488 U.S. 881 (1988). *See* RILA Br. at 8. They argue that the HCSO, by generally

mandating health care expenditures, is imposing a "contribution" mandate of the kind struck down in *J.A. Jones*. RILA Br. at 8. But again, this blurs the distinction between general expenditures and plans. The full quotation from *J.A. Jones* further underscores this distinction:

> [The statute] mandates a particular level of contributions by employers *to employee benefit plans*. . . . A statute which mandates employer contributions *to benefit plans* and which effectively dictates the level at which those required contributions must be made has a most direct connection with an employee benefit plan.

846 F.2d at 1219 (emphasis added).

In sum, no Supreme Court decision invalidates a bare expenditure requirement that provides employers with a reasonable, non-ERISA compliance option. To the contrary, the Ninth Circuit's ruling is fully supported by this Court's precedent.

IV. NUMEROUS OTHER FACTORS COUNSEL AGAINST A GRANT OF CERTIORARI.

A. Petitioner Greatly Exaggerates The Impact Of The Ninth Circuit's Ruling.

Petitioner and its *amici* contend the Ninth Circuit's ruling will cause an avalanche of "pay or play" laws to crumble down upon multijurisdictional employers. They dramatically overstate both the

possibility this will occur, and the impact it would cause.

As a preliminary matter, petitioner and its allies focus primarily on *proposals*, not actual laws. And their primary citation is to a law review article from 2006 – two years prior to when the Ninth Circuit first upheld the HCSO. *See, e.g.*, Pet. 20. Most of those proposals are long dead.[9]

As for the four measures that actually became law, petitioner and its *amici* neglect to discuss whether the Ninth Circuit's reasoning applies to those laws. It does not. The first law, from Suffolk County, New York, has already been struck down on the same ground relied upon by the Fourth Circuit: none of the purported non-ERISA compliance options was truly available to Wal-Mart, thereby effectively forcing Wal-Mart to alter its ERISA plan. *See Retail Indus. Leaders Ass'n v. Suffolk County*, 497 F. Supp. 2d 403, 417-18 (E.D.N.Y. 2007). The second law creates a board charged with establishing a universal health care program in Connecticut by mid-2010, but does not mention an employer spending requirement

---

[9] *See* H.R. 1316, 2d Reg. Sess. (Colo. 2006); S. 1618, 107th Reg. Sess. (Fla. 2006); S.B. 87, 94th Leg., 1st Reg. Sess. (Mich. 2007); S.B. 2684, 2006 Reg. Sess. (Miss. 2006); A.B. 1966, 213th Leg. (N.J. 2008); H.B. 258, 2006 Sess. (Va. 2006); H.B. 2517, 59th Leg., 2d Sess. (Wash. 2005); H.B. 4024, 77th Leg., 2d Sess. (W. Va. 2006); A.B. 860, 97th Leg., 2005-06 Sess. (Wis. 2005); H.B. 1703, 159th Sess., 2d Year (N.H. 2006).

or explain how the program will be funded. *See* 2009 Conn. Legis. Serv., Pub. Act No. 09-148 (West). Finally, Massachusetts, Vermont and New York City adopted employer health care spending requirements that include an option of making a payment to the government, but those payments, to use the words of the Ninth Circuit, give "nothing in return – either to an employer or its employees – for the employer's payment to the State," beyond what any other qualifying resident would receive. Pet. App. 37a. *See* 2006 Mass. Legis. Serv. Ch. 58 (West); 114.5 Mass. Code Regs. 16.01-.05; Vt. Stat. Ann. tit. 21, § 2003 (2009); N.Y.C. Admin. Code § 22-506.

That no other jurisdiction has enacted a program like San Francisco's, either before or after the Ninth Circuit's initial published opinion in January 2008, is unsurprising. It would be extraordinarily difficult for other jurisdictions to establish the type of non-ERISA compliance option provided by San Francisco's ordinance: payment into a comprehensive, government-run health care program that the City invested significant public dollars to build, and spends significant tax dollars to maintain. And as discussed further below, other jurisdictions are particularly unlikely to make such investments while Congress debates national health care reform, which could well include a uniform federal employer health care mandate.

Petitioner goes on to assert that if additional San Francisco-type programs do come into being, this would "overload the largest human resources

departments and the most expensive software-systems." Pet. 38. That is preposterous. As discussed above, employers commonly face differing cost (and recordkeeping) requirements in different jurisdictions, including severance pay requirements, minimum and prevailing wage requirements, vacation pay requirements, apprenticeship and/or training program requirements, taxes, tax credits, fees, and sick leave requirements. Such is the unavoidable, unremarkable consequence of doing business in multiple jurisdictions in the United States. And as discussed more fully by *amicus curiae* Nibbi Bros. Associates, multijurisdictional employers already regularly use payroll and other human resources software, provided by companies like ADP and Oracle, that are geared to facilitate compliance with disparate local requirements of this kind.

Petitioner and its allies also fail to account for the HCSO regulations that make it particularly easy for multijurisdictional employers to establish compliance. For example, one *amicus* brief asserts the ordinance will "require employers [with self-insured plans] to create a special pool of funds for San Francisco employees that is separate from the rest of the employees covered by the company plan." RILA Br. at 13. In truth, a large, multijurisdictional employer with a self-insured plan need only establish that it has spent a certain amount per employee *plan-wide*. *Supra* at 4-5. The same is true of a large employer that provides uniform health coverage to its employees through a traditional insurance plan. *Id.*

Of course, if petitioner is correct that numerous laws will sprout up and that they will be unworkable for employers, this also means the Court will have ample opportunity to consider this ERISA preemption issue in future cases. And as discussed below, future cases would have much better records.

B. The Case Is A Poor Vehicle For Consideration Of Most Arguments Made By Petitioner And Its Allies.

Two key contentions in this case have been: (i) the city payment option is not a rational choice for employers; and (ii) the ordinance imposes intolerable administrative burdens on employers. Although there was discovery in the district court, petitioner proffered no evidence to support either contention. Indeed, the record contains significant evidence to refute them both. Accordingly, this case presents a poor vehicle for consideration of an employer's claim that a general health care spending requirement is preempted by ERISA.

With respect to the argument that the city payment option is not a "rational decision" for employers,[10] petitioner had the burden of making this showing. *See, e.g., Dillingham*, 519 U.S. at 333 ("it has not been demonstrated here that the added

---

[10] Brief of *Amici Curiae* the ERISA Industry Committee and National Business Group on Health in Support of Petitioner at 17.

inducement created by the wage break available on state public works projects is tantamount to a compulsion upon apprenticeship programs"); *Travelers*, 514 U.S. at 664 ("no showing has been made here that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues"). However, in contrast to *Fielder*, where Wal-Mart presented unrebutted evidence that Maryland's law would force it to alter its ERISA plan, 274 F.3d at 193, petitioner submitted no evidence and made no showing that the choice between setting up an ERISA plan and using the city payment option was remotely a "Hobson's choice" for any employer. *Travelers*, 514 U.S. at 664. In fact, at oral argument in the Ninth Circuit, counsel for petitioner conceded that, if anything, employers had an incentive to *choose* the city payment option, which contradicted the central contention in petitioner's briefs in the district court and the Ninth Circuit.[11] And in contrast to petitioner's non-showing, the City presented unrebutted evidence that the city payment option provides a reasonable alternative. *Supra* note 3.

Petitioner also relies heavily on the argument that the HCSO's recordkeeping and other administrative obligations are burdensome. Again, this argument is made only at the highest level of abstraction. Petitioner presented no evidence to

---

[11] *See* http://www.ca9.uscourts.gov (Audio Files, No. 07-17370, first entry, minutes 31:00-34:20).

refute the common-sense notion that employers keep records of hours worked, and health care dollars spent, in the normal course of business. Nor did it present any other evidence of the exorbitant administrative burden it now alleges. The only evidence below demonstrated that one of petitioner's member restaurants – Max's – already kept the key records, including hours worked per employee and health care expenditures per employee. Resp. App. 60-62. There is no basis, on this record, to conclude that the HCSO's recordkeeping obligations are anything other than *de minimis* for employers.

C. The Result Sought By Petitioner And Its Allies Would Have A Devastating Impact On The People Of San Francisco.

In contrast to the abstract assertions by petitioner and its allies about the impact of the Ninth Circuit's ruling, the result they advocate would have a real and devastating impact on San Francisco and its residents: the City would be thrust back into the health care crisis that left more than 82,000 people without coverage, and that imposed a tremendous strain on the taxpayers by forcing public emergency rooms to treat illnesses and injuries that could have been prevented. In just 1½ years, the number of uninsured declined from roughly 82,000 to under 23,000, and the number continues to go down. Use of public emergency rooms declined *seventy percent*. Resp. App. 25-30.

Nor is the care provided by the City to the previously uninsured limited to traditional "safety net" care. Those enrolled in the HAP are receiving essential preventive and diagnostic treatment for chronic conditions such as asthma, heart disease, diabetes, hypertension or cancer. Resp. App. 25-26.

To cite just one example, a former restaurant worker with a chronic heart condition, mitral valve prolapse, was unable to obtain health insurance. She needed surgery for her condition, which would have cost her more than $100,000 if performed at a private facility, rendering it unaffordable for her. Because this person was able to join the HAP, she obtained the surgery, and believes she might not still be alive today if she had been unable to obtain this service from the City's new program. Resp. App. 26-27.

As the City showed in its response to the stay application, the universal health care program cannot survive without the employer spending requirement. Resp. App. 28-29. *See also* Brief for Zazie Restaurant as *Amicus Curiae* in Support of Respondents. Thus, the result petitioner and its allies seek is to terminate San Francisco's successful, first-of-its-kind universal health care program, based on speculation and exaggeration about the as-yet unfelt impact of the Ninth Circuit's ruling on multijurisdictional employers.

D. The Potential Enactment Of Federal Health Care Legislation Counsels Against A Grant Of Certiorari.

Finally, the question presented by the petition may be mooted by national health care reform, so granting certiorari would not be a good use of the Court's resources. As petitioner and its allies point out, Congress is considering federal legislation that would include a national employer mandate. If the predictions of petitioner and its *amici* about the enactment of such a law are correct, it would be that new law, not ERISA, that preempts the City's health care spending requirement. And if that new law preempts local health care spending requirements, the ERISA preemption issue presented here would be relevant only for a relatively brief gap period, until the effective date of the legislation.

By the same token, if Congress does not enact health care reform legislation in the next several years, and if other localities then seek to emulate San Francisco's solution to the health care crisis, the Court will have another opportunity to take up the question at that time. Either way, the present state of flux regarding national health care reform counsels against Court intervention.

CONCLUSION

The Court should deny the petition for a writ of certiorari.

Respectfully submitted,

DENNIS J. HERRERA
City Attorney
WAYNE SNODGRASS
VINCE CHHABRIA
Counsel of Record
CHRISTINE VAN AKEN
Deputy City Attorneys

Attorneys for Respondents

APPENDIX A

NO. 08A824

IN THE SUPREME COURT OF
THE UNITED STATES

OCTOBER TERM, 2008

GOLDEN GATE RESTAURANT ASSOCIATION,
Applicant,

v.

CITY AND COUNTY OF SAN FRANCISCO,
Respondent,

SAN FRANCISCO CENTRAL LABOR COUNCIL; SERVICE EMPLOYEES INTERNATIONAL UNION ("SEIU"), LOCAL 21; SEIU UNITED HEALTHCARE WORKERS-WEST; and UNITE HERE! LOCAL 2,
Intervenor/Respondents,

On Application to The Honorable
Anthony M. Kennedy, Associate Justice of the
United States Supreme Court and Circuit Justice
for the Ninth Circuit, for Order Staying Mandate
and Vacating Stay of District Court Judgment

JOINT RESPONSE TO APPLICATION FOR ORDER STAYING MANDATE AND VACATING STAY OF DISTRICT COURT JUDGMENT

STEPHEN P. BERZON
SCOTT KRONLAND
STACEY M. LEYTON
Counsel of Record
ALTSHULER BERZON LLP
177 Post Street, Suite 300
San Francisco, CA 94108
Telephone: (415) 421-7151
Facsimile: (415) 362-8064

Attorneys for Intervenor/ Respondents

DENNIS J. HERRERA
City Attorney
WAYNE SNODGRASS
VINCE CHHABRIA
Counsel of Record
CHRISTINE VAN AKEN
Deputy City Attorneys
City Hall, Room 234
One Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4682
Telephone: (415) 554-4674
Facsimile: (415) 554-4747

Attorneys for Respondent

[i] **TABLE OF CONTENTS**

TABLE OF AUTHORITIES ii

STATEMENT 5

A. The Health Care Security Ordinance 5

B. Procedural Background 8

STANDARD OF REVIEW 9

ARGUMENT 11

I. GGRA HAS FAILED TO ALLEGE, MUCH LESS ESTABLISH, IRREPARABLE HARM .. 11

II. THE EQUITIES MILITATE STRONGLY AGAINST A STAY 12

A. The Harm To GGRA And To Other Businesses Is Minimal 13

B. A Stay Would Impose Substantial Hardship On The City And Its Residents 15

III. THE CASE IS NOT WORTHY OF CERTIORARI 20

A. The Decision Below Does Not Create A Split With The Fourth Circuit 20

B. Other Factors Counsel Against A Grant Of Certiorari 24

IV. THE DECISION BELOW IS CORRECT 26

CONCLUSION 28

[ii] **TABLE OF AUTHORITIES**

Federal Cases

Barnes v. E-Systems, Inc.
501 U.S. 1301 (1991) 11

Bartlett v. Stephenson
535 U.S. 1301 (2002) 11

Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.
519 U.S. 316 (1997) 21, 29

CBS Inc. v. Davis
510 U.S. 1315 (1994) 11

Certain Named and Unnamed Non-citizen Children and Their Parents v. Texas
448 U.S. 1327 (1980) 11, 12

Fort Halifax Packing Co., Inc. v. Coyne
482 U.S. 1 (1987) 5, 27, 29

Golden Gate Restaurant Ass'n v. City and County of San Francisco
512 F.3d 1112 (9th Cir. 2008).....9

Golden Gate Restaurant Ass'n v. City and County of San Francisco
546 F.3d 639 (9th Cir. 2008) 10, 23

Golden Gate Restaurant Ass'n v. City and County of San Francisco
Supreme Court Case No. 07A654.....10

Hattem v. Schwarzenegger
449 F.3d 423 (2d Cir. 2006).....21

Keystone Chapter, Associated Builders & Contractors v. Foley
37 F.3d 945 (3d Cir. 1994).....21

Massachusetts v. Morash
490 U.S. 107 (1989).....5, 28, 29

New York State Conf of Blue Cross & Blue Shield Plans v. Travelers Ins. Co
514 U.S. 645 (1995).....5, 21, 29

[iii] *Retail Indus. Leaders Ass'n v. Fielder*
475 F.3d 180 (4th Cir. 2007) 4, 21, 22

Rostker v. Goldberg
448 U.S. 1306 (1980).....11

Ruckelshaus v. Monsanto Co.
463 U.S. 1315 (1983).....11

S. Cal. IBEW-NECA Trust Funds v. Standard Industrial Elec. Co.
247 F.3d 920 (9th Cir. 2001) 21

Whalen v. Roe
423 U.S. 1313 (1975).....11

WSB Elec. Inc. v. Curry
88 F.3d 788 (1996) 21

Federal Statutes

28 United States Code
Section 2101(f) 10

29 United States Code
Section 223(c)(1) 24
Section 1002(1) 5
Section 1002(1)(B) 27
Section 1144(b)(2)(A) 28

State Statutes & Codes

California Labor Code
Section 226 14

California Welfare & Institution Code
Section 17000 18

San Francisco Statutes, Codes & Ordinances

Department of Public Health Regulations
No. 1(b) 7
No. 7(g)(i) 7

[iv] Administrative Code
Section 14.1 (b)(7) 8
Section 14.1(b)(8) 8
Section 14.2(a) 6
Section 14.2(f) 7
Section 14.2(g) 7
Section 14.3 14

Rules

Supreme Court Rule
23.1 10

Other References

H. Knight, *Not all restaurants back suit over Healthy S.F.*
San Francisco Chronicle, Mar. 22, 2009 3

House Bill No. 2517
59th Leg., 2006 Reg. Sess. (Wash. 2006).....15

House Bill No. 2579
81st Leg., 2006 Reg. Sess. (Kan. 2006) 15

R. Gressman, K. Geller, S. Shapiro, T. Bishop & E. Hartnett, Supreme Court Practice
873 (9th. ed. 2007).....11

Senate Bill No. 1414
2005-2006 Reg. Sess. (Cal. 2006).....15

Victoria Craig Brunce et al., *Health Insurance Mandates in the States,*
Council for Affordable Health Insurance
(2008 ed.) 28

[1] INTRODUCTION

The fatal flaw in the application filed by the Golden Gate Restaurant Association ("GGRA" or "association") is its failure to provide any reason for emergency intervention. In February 2008, one month after San Francisco's health care spending requirement took effect, the Circuit Justice denied GGRA's first application for a stay. Since that time,

the City's program has become fully operational, the medium and large employers covered by the ordinance have been complying with the spending requirement for 15 months, and tens of thousands of previously-uninsured workers now have health coverage under the City's program. There is no basis for disturbing this status quo while the normal certiorari process runs its course.

As a threshold matter, a stay may not issue unless the applicant has demonstrated a likelihood of irreparable harm. Not only has GGRA failed to demonstrate irreparable harm – it has not even *alleged* irreparable harm. The association skips over this prong of the test for a stay entirely, addressing only the three subsequent prongs. This alone requires denial of the stay application.

The closest the association comes to touching upon irreparable harm is its assertion that its members, by continuing to make health care expenditures as they have done for the past 15 months, "may" suffer harm for which there is "no effective remedy." App. at 26. Such a tepid assertion could not establish irreparable harm, even if GGRA had attempted to argue that it did. Indeed, putting aside the general rule that financial loss does not warrant the kind of relief GGRA now seeks, the evidence here suggests there is no financial harm at all. GGRA's members have passed the cost of the health care spending requirement on to their customers in the [2] form of a health care surcharge, which severely undermines any claim of financial

harm. *See* Declaration of Vince Chhabria in Opposition to Application for Order Staying Mandate. In fact, just days after GGRA submitted this application, the association's own director admitted that the health care spending requirement is "working all right now." H. Knight, *Not all restaurants back suit over Healthy S.F.,* San Francisco Chronicle, Mar. 22, 2009 at B-1 (CCSF Appendix, Ex. A).

Nor would a balancing of the equities justify a stay. In addition to the alleged financial harm to its members, GGRA contends that maintenance of the current status quo would inflict harm on businesses nationwide. The association speculates that other state or local governments might emulate San Francisco's program, thereby requiring multi-jurisdictional employers to keep track of more than one local health care spending requirement. This argument primarily goes to the merits of GGRA's preemption challenge. But to the extent GGRA means to argue that laws similar to San Francisco's will crop up before the certiorari process runs its course (and that this somehow would provide a legal basis for emergency intervention), the argument is baseless. Although GGRA makes opaque reference to "similar" measures having been "proposed," it does not, and cannot, point to the actual enactment of a single law similar to San Francisco's since the Court of Appeals allowed the program to take effect 15 months ago. In fact, GGRA does not even cite a *proposal* that was made after San Francisco's program took effect – it cites only a law

review article from 2006 that listed laws proposed before the litigation even began.

Pitted against these alleged harms to the association are the very real harms that GGRA's application seeks to inflict upon the City and its [3] residents. As a result of the employer spending requirement, more than 37,000 San Francisco workers are now covered through the City's program. Staying the lower court decision, and thereby enjoining the health care spending requirement, would cause these workers to lose their coverage and access to critical diagnostic and preventive care and treatment. Moreover, elimination of the spending requirement could outright destroy San Francisco's new health care program, forcing the City to revert to the old, failed model of providing emergency care to uninsured people at public hospitals once it is too late to administer proper preventive and diagnostic care.

Aside from the equities, the case is not worthy of certiorari. Far from creating a split with the Fourth Circuit's ruling in *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007), the decision below operates in harmony with that ruling to stand for the proposition – well established by prior case law – that local governments may impose expenditure requirements on employers so long as those requirements do not interfere with plan uniformity. Moreover, the Court need not rush to decide this legal question, because the likelihood is low that other jurisdictions would quickly adopt similar health care programs. Both the success and legality of San

Francisco's program depend on the existence of a comprehensive, government-run health care delivery system that operates at great expense to the City's taxpayers. Particularly given current economic conditions, it is unrealistic to expect that other jurisdictions will rush to follow suit.

In addition, one outcome of the current debate on national health care reform could be to obviate the need for local governments to regulate in this area. Indeed, national health care legislation could moot the legal [4] question at hand, either by preempting programs like San Francisco's or by expressly authorizing them. This possibility suggests the Court should avoid venturing into the national debate on health care reform by deciding a weighty ERISA preemption question that could be mooted before it ever arises again.

Finally, even if certiorari were granted, it is unlikely the Court would reverse the decision below. GGRA's argument on the merits is that employers have the right not to be required to spend money in areas, like health care, mentioned by the ERISA statute.[1] This fails to recognize the distinction between plan uniformity, which ERISA's preemption provision protects, and expenditure uniformity, which it does not. As the Court has stated, "cost uniformity was almost certainly not an object of pre-emption . . ." *New York State Conf. of Blue Cross & Blue*

---

[1] 29 U.S.C. § 1002(1).

Shield Plans v. Travelers Ins. Co, 514 U.S. 645, 662 (1995). And as the Court has explained in cases such as *Fort Halifax Packing Co., Inc. v. Coyne,* 482 U.S. 1 (1987) and *Massachusetts v. Morash,* 490 U.S. 107 (1989), there is a reason ERISA's preemption provision explicitly singles out employee benefit "plans," rather than covering employee benefits generally. *See, e.g., Fort Halifax,* 482 U.S. at 115 ("Given the basic difference between a 'benefit' and a 'plan,' Congress's choice of language is significant in its pre-emption of only the latter"). States and localities may regulate the benefits mentioned in ERISA so long as they do not require alteration of ERISA plans. Because that is precisely what San Francisco's ordinance does, it is not preempted.

[5] STATEMENT

A. The Health Care Security Ordinance

Because GGRA's description of the ordinance is incomplete, and because its discussion of the effects of the ordinance on employers and their ERISA plans is inaccurate, we provide a brief description here.

In 2006, roughly 82,000 San Francisco adults suffered from a lack of health insurance – more than one-tenth of the City's population. CCSF Appendix, Ex. B at 3.[2] In response to this health care crisis, the

---

[2] A common misconception about the uninsured is that they are "taken care of" because they qualify for state or federally funded health care programs for the indigent like Medi-Cal

(Continued on following page)

San Francisco Board of Supervisors unanimously passed, and the Mayor signed into law, the Health Care Security Ordinance ("HCSO" or "ordinance"). The ordinance has two key related components – a government health care program and an employer health spending requirement.

The government health care program is operated by the San Francisco Department of Public Health ("DPH"). Its primary feature is the Health Access Program ("HAP"), which delivers health care to its participants from a network consisting of San Francisco General Hospital, DPH clinics, and participating non-profit and private providers. S.F. Admin. Code § 14.2(a).[3] The HAP assigns a primary care physician, nurse practitioner or physician assistant to each participant. And it provides "medical services with an emphasis on wellness, preventive care and [6] innovative service delivery." S.F. Admin. Code § 14.2(f). Among the specific services provided are inpatient and outpatient hospital services, diagnostic and laboratory services, radiological services, mental

---

(California's Medicaid program). In reality, most people without health care do not qualify for such programs; rather, they simply go without care or resort to trips to the emergency room when it is too late to receive proper preventive treatment (and then are billed for the high cost of such trips). The 82,000 San Francisco residents who were uninsured do not include the people who were already enrolled in San Francisco's indigent health care programs. CCSF Appendix, Ex. B at 4.

[3] The ordinance, along with the implementing regulations, can be found at CCSF Appendix, Ex. B.

health services, home health care, and prescription drug benefits. *Id.* The value of this care is substantial – DPH estimated that in 2008 it cost an average of $261 per participant per month to provide it.[4] CCSF Appendix, Ex. B at 5.

The HAP, which is funded in large part by the City's general fund, is available to uninsured San Francisco residents, regardless of whether they are employed or unemployed. Enrollees must pay quarterly participation fees to receive HAP coverage.[5]

The other key component of the HCSO is the employer spending requirement – a mandate that medium and large businesses make minimum health expenditures on behalf of employees who work more than a specified number of hours. Specifically, in 2008 private employers with 20-99 employees and nonprofit employers with 50 or more employees were

---

[4] Incidentally, DPH changed the name of the HAP program to "Healthy San Francisco" after determining that the name "Health Access Program" would create confusion among San Francisco residents because of its similarity to other programs. See DPH Reg. No. 1(b). For purposes of this litigation the parties have continued to use the name contained in the ordinance.

[5] Individual residents who work in San Francisco but live elsewhere do not qualify for HAP participation, but the program contains a feature for those people as well. The ordinance authorizes DPH to establish and maintain medical reimbursement accounts for qualified nonresident employees who work in the City. S.F. Admin. Code §§ 14.1(b)(7), 14.2(g). Beneficiaries of this aspect of the City's program may draw from their accounts to obtain reimbursement for medical expenses, including payments of health insurance premiums. DPH Reg. No. 7(g)(i).

required, for any employee who has been employed for 90 days and works more than ten hours per week, to make health care expenditures of $1.17 per hour on behalf of that employee. Private employers with 100 or more employees were required to make health care expenditures of $1.76 per [7] hour on behalf of each covered employee. S.F. Admin. Code. § 14.1(b)(8); OLSE Reg. No. 5.2(A)(1).[6]

It is entirely up to each covered employer to decide how to comply with this spending requirement. The Ordinance defines health care expenditures to mean "any amount paid by a covered employer to its covered employees or to a third party on behalf of its covered employees for the purpose of providing health care services for covered employees or reimbursing the cost of such services for its covered employees." S.F. Admin. Code § 14.1(b)(7). The ordinance makes clear that employers may set up health care plans themselves, or, of they prefer not to do so, they may make payments to the City on behalf of their workers (hereinafter "the city payment option"). *Id.* They may also fulfill the expenditure obligation through a combination of the two. The program is structured so that, if an employer chooses the city payment option,

---

[6] The amount has increased slightly for 2009: $1.85 per hour for large employers and $1.23 per hour for medium employers. OLSE Reg. No. 5.2(B). GGRA has argued that the amount will skyrocket after 2010, CCSF Appendix, Ex. A, but that is false, and in any event, not relevant to whether a stay should be in effect during the certiorari process.

it need only write a check and all employees on whose behalf the payment is made will be eligible to receive health care benefits.

Covered employees who qualify for HAP membership are, if their employers choose to satisfy the spending requirement by paying the City, entitled to enroll in the program at a 75% discount on the quarterly participation fees they would otherwise be required to pay. DPH Reg. No. 7(f). Furthermore, any covered employee whose fee, after the 75% discount, falls below $50 per quarter is simply allowed to enroll for free. *Id.*

[8] According to studies compiled by the San Francisco Controller's Office, the large majority – approximately ninety percent – of businesses with 20 or more employees already provided health care benefits to their employees at the time the ordinance was enacted. CCSF Appendix, Ex. B at 9. The average monthly health insurance premium in California at that time was $379. *Id.*

The employer health care spending requirement has now been in effect for 15 months. As a result, 37,000 San Francisco workers are covered under the government health program described above. Declaration of Dr. Mitchell H. Katz in Opposition to Application for Order Staying Mandate at ¶ 11. Thousands of others are enrolled in the program separate and apart from any payment made by an employer. *Id.* Overall, the number of San Francisco

residents without health coverage is down to under 23,000, and counting. *Id.* at ¶10.

B. Procedural Background

On December 26, 2007, the district court ruled that the ordinance was preempted by ERISA. The next day, the City and Intervenors filed an emergency application with the United States Court of Appeals for the Ninth Circuit, seeking an order staying the district court's ruling and allowing the employer spending requirement to take effect pending appeal. On January 9, 2008, the Ninth Circuit granted this request, ordered expedited briefing, and set an accelerated date for oral argument on the merits. *Golden Gate Restaurant Ass'n v. City and County of San Francisco,* 512 F.3d 1112 (9th Cir. 2008).

After waiting more than one month after the emergency application was granted, GGRA filed an application for a stay of the Ninth Circuit's order with the Circuit Justice. GGRA made arguments that are precursors [9] to the ones it raises in the present application, namely, that restaurants could suffer financial harm if the spending requirement were allowed to take effect, that the ordinance would require them to keep records, and that businesses could be subject to multiple health care spending obligations as a result of the ordinance. The Circuit Justice denied the stay application. *Golden Gate Restaurant Ass'n v. City and County of San Francisco,* Sup. Ct. Case No. 07A654.

Oral argument on the merits in the Court of Appeals took place on April 17, 2008, and the panel issued its ruling on September 30, 2008, reversing the district court and concluding San Francisco's ordinance is not preempted. *Golden Gate Restaurant Ass'n v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008) ("*GGRA II*"). GGRA did not ask the panel for a stay at that time. Instead, it filed a petition for rehearing en banc (but it did not ask the en banc court for a stay either). The en banc petition was denied on March 9, 2009. GGRA Appendix, Ex. F. The mandate issued on March 17, 2009. Meanwhile, San Francisco's health care spending requirement has been in effect, the restaurants and other employers have been complying with it, and 37,000 workers obtained health coverage from the City's program as a result.

STANDARD OF REVIEW

An application for a stay brought pursuant to Supreme Court Rule 23.1 and 28 U.S.C. § 2101(f) may not be granted unless: (1) the applicant demonstrates a likelihood of irreparable harm; (2) the equities favor a stay; (3) there is a reasonable probability that four members of the Court would consider the underlying issue worthy of certiorari; and (4) there is a significant possibility that the Court will reverse the decision below. *See, e.g., Certain Named and Unnamed Non-citizen Children and Their Parents* [10] *v. Texas*, 448 U.S. 1327, 1330 (1980) ("*Non-citizen Children*") (Powell, J., in chambers).

It bears emphasis that if an applicant fails to demonstrate a likelihood of irreparable harm, the stay application must be denied for that reason alone, rendering consideration of the other elements of the test unnecessary. *See Whalen v. Roe*, 423 U.S. 1313, 1316 (1975) (Marshall, J., in chambers) (conclusion that applicant has shown no irreparable harm "necessarily decides the application and renders unnecessary" any consideration of the remaining elements). *See also Ruckelshaus v. Monsanto Co.*, 463 U.S. 1315, 1317 (1983) (Blackmun, J., in chambers).

However, if an applicant does demonstrate irreparable harm, this does not obviate the need to inquire whether the equities justify a stay, including whether a stay would be in the public interest. "It is ultimately necessary, in other words, 'to balance the equities – to explore the relative harms to applicant and respondent, as well as the interests of the public at large.'" *Barnes v. E-Systems, Inc.*, 501 U.S. 1301, 1305 (1991) (Scalia, J., in chambers) (quoting *Rostker v. Goldberg*, 448 U.S. 1306, 1308 (1980) (Brennan, J., in chambers)). *See Generally* R. Gressman, K. Geller, S. Shapiro, T. Bishop & E. Hartnett, Supreme Court Practice 873 (9th. ed. 2007).

More generally, in the context of an in-chambers stay application, there is a "presumption that the decisions below – both on the merits and on the proper interim disposition of the case – are correct." *Rostker*, 448 U.S. at 1308. Accordingly, a Circuit Justice "will grant a stay only in extraordinary circumstances." *Bartlett v. Stephenson*, 535 U.S. 1301,

1304 (2002) (Rehnquist, C.J., in chambers) (quoting *Whalen*, 423 U.S. at 1316). *See, e.g., CBS Inc. v. Davis*, 510 U.S. 1315, 1317 (1994) (Blackmun, in [11] chambers) ("extraordinary circumstances" present where lower court ruling would lead to "indefinite delay" of broadcast that would "cause irreparable harm to the news media that is intolerable under the First Amendment").

ARGUMENT

I. GGRA HAS FAILED TO ALLEGE, MUCH LESS ESTABLISH, IRREPARABLE HARM.

There is a fatal omission in GGRA's application. It argues three of the four requirements for a stay: that there is a reasonable probability the Court will grant certiorari, App. at 8, that there is a significant possibility the Court will reverse the decision below, App. at 12, and that the "balance of equities" favors the association. App. at 24. But the application completely omits any discussion of whether there is a likelihood of irreparable harm. GGRA has submitted no evidence, made no factual assertions, and advanced no legal argument about irreparable harm. Accordingly, no further inquiry is needed – the application must be denied for failure to allege, much less demonstrate, irreparable harm. *See* p. 11, *supra*.

The only portion of the application that could be construed as relating to irreparable harm (even though GGRA does not characterize it as such) is the statement that, absent a stay, restaurants with more

than 20 employees will continue making health care expenditures under the ordinance, as they have done for the past 15 months. GGRA asserts that there "may" not be an "effective remedy" for this alleged injury. App. at 26. Putting aside the general rule that monetary injury does not give rise to relief of this kind, *cf. Non-citizen Children*, 448 U.S. at 1332-34, in this case the evidence indicates there has been no financial harm at all – irreparable or otherwise. Shortly after the program took effect, restaurants in San Francisco began passing the cost of the health care spending [12] requirement on to their customers, in the form of a "Healthy San Francisco" surcharge. *See* Chhabria Decl., Ex. A (receipts and menus reflecting surcharge). Indeed, because restaurants have successfully passed on this cost, and because San Francisco restaurant patrons have been widely supportive of it, GGRA's own director has publicly stated that the health care expenditure requirement is "working all right now." CCSF Appendix, Ex. A. This statement from GGRA's director came just days after GGRA submitted its emergency application to the Circuit Justice. Perhaps that is why GGRA is unwilling to allege its members suffer from irreparable financial harm.

II. THE EQUITIES MILITATE STRONGLY AGAINST A STAY.

Even if one were to assume irreparable harm despite GGRA's failure to allege it, the equities would

not justify a stay. In fact, compared to when GGRA sought a stay from the Circuit Justice 13 months ago, the equities in favor of the City and its residents are now much stronger. Back then, the City had only begun implementing its program, the medium and large employers impacted by the spending requirement had not yet developed their systems for making health care expenditures, and workers had not yet obtained health coverage as a result of payments by their employers. Now, the program is fully operational, the medium and large employers have been making their payments, and roughly 37,000 workers enjoy health coverage from the City as a result. A stay would disturb this status quo by stripping people of their health coverage, and could potentially destroy the City's new universal health program in the process.

[13] **A. The Harm To GGRA And To Other Businesses Is Minimal.**

Aside from GGRA's tepid and unsupportable assertion of financial hardship, the association claims its members are being harmed by the ordinance's recordkeeping requirements. App. at 26. But those requirements are neither onerous nor complex. GGRA's members must maintain itemized pay statements, which is already mandated by California Labor Code section 226. The ordinance requires them to maintain the name, address, phone number and first day of work of each employee, and records of health care expenditures made on behalf of those

employees. And they must file annual reports with the City to prove quarterly compliance, which simply involves dividing the amount spent on health care by the hours worked by covered employees. S.F. Admin Code § 14.3. GGRA has not explained how maintaining these records or reporting this information would harm its members. Indeed, GGRA has not explained why such information would not already be maintained in the normal course of business.

Beyond the purported recordkeeping hardship for GGRA's members, the association makes passing reference to alleged financial and recordkeeping hardship that other San Francisco employers covered by the ordinance would suffer if the program continues during the certiorari process. However, no other San Francisco employer has challenged the validity of the program, and accordingly there is no reason to assume that businesses other than some of GGRA's members consider themselves harmed by it. Indeed, the great majority of medium and large employers in San Francisco actually benefit from the health care spending requirement, because they were already providing health insurance to their employees. CCSF Appendix, Ex. B at 9. Any employer that previously spent enough [14] money on health care to satisfy the ordinance is no longer at a competitive disadvantage vis-a-vis the minority of

medium and large employers that had chosen not to spend money on employee health benefits.[7]

GGRA next asserts that the decision below inflicts harm beyond San Francisco, because it could cause multi-jurisdictional employers to be subjected to a flood of different health care spending obligations. To the extent GGRA means to contend that multi-jurisdictional employers will be subjected to different spending obligations *during the certiorari process,* that is without any support. GGRA has not identified a single piece of legislation that has even been proposed, much less enacted, since the Court of Appeals allowed San Francisco's program to take effect 15 months ago. Instead, it cites a law review article from 2006 – before San Francisco's ordinance was even enacted – for the proposition that "over thirty similar statutes *had been* proposed . . . " App. at 9 (emphasis added). The claim of impending nationwide hardship during the certiorari process is illusory.

Even if proposals like the ones listed in GGRA's law review article were pending today, this still would not be a hardship. First, many of those proposals were similar or identical to the Maryland law struck

---

[7] Moreover, even those medium and large employers whose health care spending was affected by the ordinance have received a benefit, because their employees have received health coverage as a result, thereby blunting any claim of harm to those busiresses.

down by the Fourth Circuit, and dramatically different from the ordinance San Francisco has enacted.[8] As discussed in Section III, the Ninth Circuit explained that San Francisco's ordinance was not preempted precisely because of its differences from the Maryland law. Second, the claim of hardship for [15] multi-jurisdictional employers presumes that GGRA is correct on the merits – specifically, that local governments may not impose spending requirements on employers. But as discussed in Section IV, this Court has already made clear that ERISA does not protect employers from local payment requirements merely because they apply to areas mentioned by ERISA.

GGRA's final claim of hardship relates in some fashion to the stimulus package recently passed by Congress and signed into law by the President. App. at 25. The association observes that the ordinance, by allowing San Francisco employers to comply with the health care spending requirement by making payments to the City for their employees' benefit, has given those employers a means to provide health coverage that would not be covered by COBRA. It is difficult to understand what hardship this creates. GGRA seems to be assuming that workers who received no coverage prior to the ordinance, but who

---

[8] *See., e.g.*, Senate Bill No. 1414, 2005-2006 Reg. Sess. (Cal. 2006); House Bill No. 2579, 81st Leg., 2006 Reg. Sess. (Kan. 2006); House Bill No. 2517, 59th Leg., 2006 Reg. Sess. (Wash. 2006).

now receive comprehensive coverage from the City, are worse off than before because COBRA does not apply to the HAP. This makes no sense. GGRA's invocation of COBRA and the stimulus package appears to be nothing more than an attempt to manufacture one issue not already presented in its unsuccessful stay application from last year.

B. A Stay Would Impose Substantial Hardship On The City And Its Residents.

Since San Francisco's program took effect, the number of residents without health coverage has been reduced from 82,000 to fewer than 23,000. Katz Dec. at ¶ 10. And as a direct result of the employer spending requirement, more than 37,000 workers now have health coverage from the [16] City's program. *Id.* at ¶ 11.[9] A substantial percentage of those enrolled in the program are receiving essential preventive and diagnostic care for chronic conditions such as asthma, heart disease, diabetes, hypertension or cancer. In all, the HAP has so far provided 73,414 health visits, filled 83,200 prescriptions for medication, and performed 2,350 surgical procedures. 41% of those health visits were for conditions that, if left untreated, would lead to heart disease. Another 45% were for conditions that, if left untreated, would lead

---

[9] This does not even account for the thousands of workers whose employers chose to provide coverage themselves rather than complying through the city payment option. The City has not yet collected data on this point.

to hospital-based emergency department overuse. *Id.* at ¶¶ 12-14. In short, San Francisco is well on its way to resolving its health care crisis.

GGRA's application seeks to force San Francisco back into the old, failed paradigm for health care delivery that the City and its health officials have worked so hard to escape. Most immediately, elimination of the employer spending requirement would deprive these 37,000 workers of their existing health coverage through San Francisco's program. *Id.* at ¶ 15. This loss of coverage would likely cause substantial numbers of these individuals to cancel planned medical visits and surgeries, forego ongoing medical treatment and prescription medicine, and otherwise take health risks that will result in major declines in health and unnecessary hospitalizations. *Id.* And it has been firmly established that when people lose their health coverage, they receive less care, they are likely to experience major declines in health, and are more likely to be hospitalized. *Id.* Particularly given that many HAP participants have chronic conditions that require regular treatment and monitoring in order to avoid significant [17] health risks and complications, serious human suffering would result if the stay were granted.

To cite an example the Director of Public Health provides to illustrate the importance of the program, one former restaurant worker with a chronic heart condition, mitral valve prolapse, was unable to obtain health insurance. She needed surgery for her condition, which would have cost her more than $100,000

if performed at a private facility, rendering it unaffordable for her. Because this person was able to join the HAP, she obtained the surgery, and believes she might not still be alive today if she had been unable to obtain this service from the City's new program. *Id.* at ¶ 16.

GGRA misleadingly suggests none of this matters because San Francisco "already has an obligation," under state law, "to provide health services to its residents." App. at 27. What California law actually states is that counties must provide health services to "indigent" residents. Cal. Welf. & Inst. Code § 17000. Residents who qualify for indigent health care services are deemed "insured" for purposes of this measurement, and therefore the residents who qualify as "indigent" for purposes of this code section were not part of the group of 82,000 uninsured residents that existed before the ordinance became operative. CCSF Appendix B at 4. Accordingly, this state law provision will do nothing to diminish the adverse consequences of a stay for San Francisco and its residents.

The association also suggests that even if the 37,000 workers lost their existing health coverage, the harm they would suffer is speculative because, should they encounter health problems, they might still seek emergency care at San Francisco General Hospital. App. at 28. But reliance on public hospital emergency rooms to provide care to the [18] uninsured is the very embodiment of the health care crisis the ordinance seeks to address (and that is now a

subject of national debate, as discussed *infra*). As the brief of the California Medical Association demonstrated below, a system that relies on use of emergency rooms by the uninsured imposes a tremendous financial strain on local governments, prevents emergency rooms from actually saving lives in true medical emergencies, and deprives the uninsured of the preventive care, diagnostic care, and the monitoring they need to avoid emergencies in the first place. CCSF Appendix, Ex. C at 8-12. Following enactment of the ordinance, emergency room visits to San Francisco General Hospital went down almost *seventy percent* – from 29,976 in the second quarter of 2007 to 8,944 in the second quarter of 2008. *Id.* at 5. GGRA's suggestion that there would be no harm in returning to the old way of dealing with the health care crisis is, to put it charitably, crass.

Even beyond the 37,000 workers who are currently covered, shutting down the health care spending requirement could destroy the City's health care program altogether. If the City were to offer comprehensive health care to its residents without an employer spending requirement, there would be tremendous incentive for employers that currently provide health insurance to their workers to drop that coverage, on the assumption that the workers will simply be absorbed into the HAP. Indeed, workers themselves might prefer that their employer-based coverage be dropped in exchange for a wage increase, given the availability of comprehensive health coverage from the HAP. The impact of this

shift could be tremendous – it bears repeating that, prior to enactment of the ordinance, roughly 90% of medium and large employers already provided health insurance to their employees. If even a meaningful portion of those [19] workers were foisted onto the City's program, the strain on the HAP may be too great to bear. Katz Decl. at ¶ 18. The City, in this time of budget shortfalls, cannot realistically be expected to invest the even greater amounts of public dollars that would be necessary to achieve universal health care in the face of widespread cancellation of employer-based health plans, not to mention the loss of tens of millions of dollars in annual revenue the HAP receives from employer payments. *Id.* at ¶ 11.

Finally, the equities tip sharply on the side of the City because it has invested a tremendous amount of money and time to bring the employer spending requirement into operation, all of which would have to be repeated if the requested stay was entered and the law was subsequently upheld. Over the past year, the City has invested hundreds of thousands of dollars on a widespread educational campaign to inform employers of the ordinance and educate them about their compliance options. Katz Decl. at ¶ 7. And it has spent millions of dollars to create enrollment systems and other tools to ensure that employers and their workers would readily benefit from the coverage under the City's program. *Id.* at ¶ 9. If the health care spending requirement were to be shut down, only to resume again a year later (after favorable ruling by this Court or, say, an act of Congress that explicitly

authorized the program while the case is still pending), much of this time and expenditure would have been wasted, and would have to be repeated. *Id.* at ¶ 8.

In short, the hardship alleged by GGRA pales in comparison to the harm the City and its residents would suffer should GGRA succeed in its effort to obtain a stay.

[20] **III. THE CASE IS NOT WORTHY OF CERTIORARI.**

A. The Decision Below Does Not Create A Split With The Fourth Circuit.

The circuits are in agreement that "[w]here a legal requirement may be easily satisfied through means unconnected to ERISA plans, and only relates to ERISA plans at the election of an employer, it affects employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Keystone Chapter, Associated Builders & Contractors v. Foley*, 37 F.3d 945, 960 (3d Cir. 1994) (internal quotations, citations and brackets omitted). *See also Fielder*, 475 F.3d at 193; *Hattem v. Schwarzenegger*, 449 F.3d 423, 429 (2d Cir. 2006); *S. Cal. IBEW-NECA Trust Funds v. Standard Industrial Elec. Co.*, 247 F.3d 920, 925 (9th Cir. 2001); *WSB Elec. Inc. v. Curry*, 88 F.3d 788, 795 (1996).

This agreed-upon rule is based on this Court's authority, which establishes that local laws which *influence choices* relating to ERISA plans are not

preempted unless the influence on an employer's choice is so great that it amounts to a *substantive mandate* regarding an ERISA plan. *See Travelers Ins.*, 514 U.S. at 664 ("Although even in the absence of mandated coverage there might be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate, no showing has been made here that the surcharges are so prohibitive as to force all health insurance consumers to contract with the Blues"); *see also Cal. Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 332-33 (1997).

Far from creating a split, the decisions of the Fourth Circuit in *Fielder* and the Ninth Circuit in this case, taken together, do nothing more than apply these well-established principles in the context of health care spending. As the Fourth Circuit explained, the spending requirement at [21] issue in *Fielder* was preempted because it imposed a penalty that forced the employer to alter its ERISA health care plan, while, as the Ninth Circuit explained, San Francisco's ordinance is not preempted because it creates a comprehensive government health care program into which employers may pay on behalf of their workers, thereby providing them with a reasonable compliance option that does not involve the alteration of an existing ERISA plan or the creation of a new plan.

Specifically, *Fielder* involved a preemption challenge to Maryland's Fair Share Act, which

provided that any Maryland for-profit employer with more than 10,000 employees that does not spend up to 8% of its payroll on health insurance (*i.e.*, Wal-Mart) must make up the deficiency by paying it to the Secretary of Labor. *Id.* at 184. The Secretary of Labor was authorized to use the proceeds of any payments by Wal-Mart to fund Maryland's Medicaid program. *Id.* Wal-Mart's employees would not receive any additional benefits, services, or cost savings in return for such payments. *Id.* at 193.

Recognizing that a law which "effectively mandates some element of the structure or administration of employers' ERISA plans" is preempted while a law that "do[es] not bind the choices of employers or their ERISA plans" is generally permissible, the Fourth Circuit concluded that the Fair Share Act fell within the former category and was thus invalid. *Id.* at 193. The Court reasoned that the Maryland law effectively required Wal-Mart to alter its ERISA plan because no rational employer would choose to pay this money to the State when it could instead increase health care spending in a manner that benefited its employees:

> In effect, the only rational choice employers have under the Fair Share Act is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold. The Act thus falls squarely under [22] *Shaw*'s prohibition of state mandates on how employers structure their ERISA plans.

Id. at 193-194.

As the Ninth Circuit explained, San Francisco's ordinance, "[i]n stark contrast to the Maryland law, . . . offers employers a meaningful alternative that allows them to preserve the existing structure of their ERISA plans." *GGRA II*, 546 F.3d at 660. Employees whose employers comply through payments to the City, rather than by establishing or altering ERISA plans, receive "tangible benefits" in return. *Id.*

Highlighting the reasonableness of this choice as compared to the penalty in Maryland, 894 employers have selected the city payment option since the health care spending obligation took effect. Katz Decl. at ¶ 11. That so many employers have selected the city payment option is not surprising, since it allows employers to avoid the inconvenience of setting up their own ERISA plans, while ensuring that their workers will receive comprehensive health coverage from the City at a price far lower than it would cost in the private market.[10]

---

[10] Specifically, by simply writing a check to the City, employers avoid a burden that may include hiring an employee benefits consultant, learning about and deciding among the many benefit options, contracting with a third party administrator to maintain the plan and process employee claims, preparing the disclosure documentation required by ERISA, complying with ERISA's reporting requirements, and potentially exposing themselves to ERISA-related litigation. And the health benefits received by employees from the City will often be extraordinarily generous in relation to the amount paid by the employer. As discussed at pp. 7-9, *supra*, the average insurance premium in California $379 per month when the ordinance took effect. In contrast, for a medium sized employer with an

(Continued on following page)

[23] Notwithstanding this, GGRA claims an inter-circuit conflict based on the Fourth Circuit's discussion of an issue that was not presented to, or considered by, the Ninth Circuit here. Specifically, after holding that the option of paying the government was nothing more than a penalty that forced Wal-Mart to alter its ERISA plan, the court went on to address Maryland's alternative argument that Wal-Mart had other, private non-ERISA means for complying. These alternatives, according to Maryland, were to satisfy the spending requirement through the creation and administration of on-site medical clinics, or through the establishment of Health Savings Accounts ("HSAs"). The court rejected this argument on the ground that the purported alternatives were unrealistic. 475 F.3d at 196. And *then* the court observed that even if Wal-Mart could avail itself of these options, doing so would necessarily also produce a change in the company's ERISA plan:

> If Wal-Mart were to attempt to utilize non-ERISA health spending options to satisfy the Fair Share Act, it would need to coordinate

---

employee who works 20 hours per week, the employer could satisfy its spending obligation in 2008 by paying the City $93.60 per month. This allowed the employee to obtain a membership that provides comprehensive health services, which cost the City on average $261 per month to provide. In other words, if the employer chooses the government payment option, its employees receive comprehensive health benefits for pennies on the dollar, and the City picks up the rest of the tab.

> those spending efforts with its existing ERISA plans. For example, an individual would be eligible to establish a Health Savings Account only if he is enrolled in a high deductible [ERISA] health plan. *See* 29 U.S.C. § 223(c)(1). In order for Wal-Mart to make widespread contributions to Health Savings Accounts, it would have to alter its package of ERISA health insurance plans to encourage its employees to enroll in one of its high deductible health plans. From the employer's perspective, the categories of ERISA and non-ERISA healthcare spending would not be isolated, unrelated costs. Decisions regarding one would affect the other and thereby violate ERISA's preemption provision.

Id. at 196-97. As Judge William Fletcher pointed out in his opinion concurring in the denial of rehearing en banc, GGRA and the dissenting judges omit the sentences from the above passage which show that the [24] Fourth Circuit was addressing Maryland's specific argument pertaining to on-site medical clinics and HSAs. GGRA Appendix, Ex. F.

Accordingly, the decisions of the Fourth and Ninth Circuits are not in conflict. Both decisions apply well-established precedent, and their holdings operate in harmony to reaffirm the general ERISA preemption principle – in the specific context of heath care – that while a local government may not effectively force employers to alter or adopt ERISA plans, it may impose spending obligations that allow

employers to comply while leaving ERISA plans undisturbed.[11]

B. Other Factors Counsel Against A Grant Of Certiorari.

Particularly given the absence of an inter-circuit conflict, even if the Court believes this ERISA preemption issue may someday be worthy of review, there are substantial reasons to avoid confronting the issue at this time, in the context of this case.

First, there is no serious possibility that other jurisdictions will adopt programs like San Francisco's in the near future. GGRA has cited only measures that were proposed prior to 2006; it does not cite one measure proposed after the Ninth Circuit allowed San Francisco's program to take effect. Furthermore, many of those pre-2006 proposals were similar or identical to the law struck down by the Fourth Circuit, *See* p. 15, supra. Under the Ninth Circuit's reasoning, proposals of this kind have not been given new life.

---

[11] GGRA also contends this case is worthy of certiorari because the decision below conflicts with the decisions of this Court. Because, in reality, a ruling striking down San Francisco's program would require the Court to jettison its existing precedent, GGRA's contention in this regard is more appropriately addressed in Section IV, which explains why a majority of the Court would be unlikely to reverse the decision below.

[25] Moreover, it would be extraordinarily difficult for other jurisdictions to establish the type of reasonable non-ERISA compliance option provided by San Francisco's ordinance: payment into a comprehensive, government-run health care program that the City invested significant public dollars to build, and spends significant public dollars (substantially more than that received from employer payments) to maintain. Particularly in this time of financial hardship for state and local governments, it will be challenging indeed to follow in San Francisco's footsteps.

Of course, if that turns out wrong, and if GGRA's dire forecast of multiple health care obligations across jurisdictions bears out, then the Court will have ample opportunity to address the matter in the future. But because there is no reason to credit GGRA's assertion that multiple laws are on the verge of sprouting up, and because GGRA's contention that compliance with multiple spending requirements will be unworkable for employers is presently based on pure speculation, intervention by the Court is not required at this time.

On a related note, the national discussion on President Obama's proposal for health care reform is beginning in earnest, and there are reasons for the Court to avoid venturing into that discussion. Generally speaking, the enactment of national heath care legislation could obviate the need for local governments to act separately to address the health care crisis – indeed, this is presumably another

reason other jurisdictions are not rushing to build programs of the HAP's magnitude. And if the federal government enacts legislation that includes an employer spending requirement as the President has proposed, this would presumably preempt local requirements like San Francisco's. Or, national health care reform may take another route, by explicitly authorizing local requirements like [26] San Francisco's. Either way, the outcome of the health care debate could very well moot the ERISA preemption issue GGRA urges the Court to take up immediately.

IV. THE DECISION BELOW IS CORRECT.

Finally, even if the Court were to grant certiorari, it would likely affirm the decision below. GGRA's argument on the merits is that local governments may not subject employers to health care expenditure requirements. This argument rests on the assumption that when it comes to matters (like health care) that are mentioned in ERISA, local governments simply may not impose expenditure requirements. This Court has rejected that assumption. Indeed, the Court would be required to repudiate the principles expressed in its existing ERISA preemption cases to rule in GGRA's favor.

Although ERISA's preemption provision protects employers' ability to maintain *plan* uniformity, it does not guarantee *expenditure* uniformity for employers. For example, in *Fort Halifax,* the Court held that a

state law requiring minimum severance pay expenditures was not preempted because it did not interfere with plan uniformity. The Court made clear that states and localities may regulate the benefits mentioned in ERISA so long as they do not require alteration of ERISA plans:

> Appellant's basic argument is that any state law pertaining to a type of employee benefit listed in ERISA necessarily regulates an employee benefit plan, and therefore must be pre-empted. Because severance benefits are included in ERISA, *see* 29 U.S.C. § 1002(1)(B), appellant argues that ERISA pre-empts the Maine statute. In effect, appellant argues that ERISA forecloses virtually all state legislation regarding employee benefits. This contention fails, however, in light of the plain language of ERISA's pre-emption provision, the underlying purpose of that provision, and the overall objectives of ERISA itself. . . . ERISA's pre-emption provision does not refer to state laws relating to "employee benefits," but to state laws [27] relating to "employee benefit *plans*" . . . The words "benefit" and "plan" are used separately throughout ERISA, and nowhere in the statute are they treated as the equivalent of one another. Given the basic difference between a "benefit" and a "plan," Congress' choice of language is significant in its pre-emption of only the latter.

482 U.S. at 7-8 (emphasis in original).

Similarly, in *Morash,* the Court considered the preemptive effect of ERISA on state laws requiring the payment of unused vacation benefits to employees upon their discharge. Even though vacation pay is listed in ERISA, the Court concluded that such state laws are not preempted, so long as they do not infringe upon ERISA plans. 490 U.S. at 114-15.

In the area of health care itself, the very structure of ERISA necessarily contemplates that employers will be subject to disparate costs across jurisdictions. After all, ERISA's savings clause exempts from preemption state laws regulating insurance. 29 U.S.C. § 1144(b)(2)(A). This has resulted in the enactment of more than 1,961 mandates on health insurance, and no two states impose identical sets of coverage mandates. Victoria Craig Brunce et al., *Health Insurance Mandates in the States,* Council for Affordable Health Insurance (2008 ed.) at 1. Accordingly, the cost of employer-provided health insurance varies wildly from state to state. *Id.* at 3-5.

Congress never could have included the savings clause if it had viewed ERISA as preserving expenditure uniformity for employers in the area of health care. "Such disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 747 (1985). And that is why "*cost uniformity was almost certainly not an object of pre-emption*, just as laws with only an indirect economic effect on the relative [28] costs of various health insurance packages in a given State

are a far cry from those 'conflicting directives' from which Congress meant to insulate ERISA *plans*." *Travelers*, 514 U.S. at 662 (emphasis added).

The upshot is that employers commonly face differing cost (and recordkeeping) requirements in different jurisdictions. They are subject to varying severance pay requirements, minimum wage requirements, vacation pay requirements, apprenticeship and/or training program requirements, taxes, fees, and sick leave requirements, to name just a few. And a requirement in one of these areas may affect the employer's decision about expenditures in another area. Such is the unavoidable (and utterly unremarkable) consequence of doing business in multiple jurisdictions in the United States.

In sum, ERISA does not insulate businesses from being required to spend money. Local requirements are only preempted if they interfere with *plan* uniformity, and as discussed at length herein, San Francisco's ordinance does not do that. To reverse the decision below, the Court would be required to repudiate the principles discussed above, as well as the cases that articulate them, such as *Fort Halifax, Morash, Travelers,* and *Dillingham*. Accordingly, it is unlikely that five Justices of this Court would rule in GGRA's favor on the merits.

[29] **CONCLUSION**

The application for a stay should be denied.

Dated: March 27, 2009

Respectfully submitted,

DENNIS J. HERRERA
City Attorney
WAYNE SNODGRASS
VINCE CHHABRIA
CHRISTINE VAN AKEN
Deputy City Attorneys

By: /s/ Vince Chhabria
VINCE CHHABRIA

Attorneys for Respondent

STEPHEN P. BERZON
SCOTT A. KRONLAND
STACEY M. LEYTON
ALTSHULER BERZON LLP

By: /s/ SML/rc
STACEY M. LEYTON

Attorneys for
Intervenor/Respondents

APPENDIX B

City and County of San Francisco
Department of Public Health

101 Grove Street
San Francisco, CA 92402
Telephone: (415) 554-2600
Facsimile: (415) 554-8111

[SEAL]

REGULATIONS IMPLEMENTING HEALTHY SAN FRANCISCO AND MEDICAL REIMBURSEMENT ACCOUNT PROVISIONS OF THE SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE

1. Purpose

(a) The purpose of these Regulations is to implement Chapter 14, Sections 14.2 and 14.4 of the San Francisco Administrative Code, the San Francisco Health Care Security Ordinance ("HCSO" or "Ordinance") which authorizes the Department of Public Health ("DPH") to: (i) create and administer a program to provide health care services to San Francisco's uninsured residents; and (ii) establish and maintain Medical Reimbursement Accounts for non-residents who work in San Francisco and other qualified individuals.

(b) The program referenced in subsection (a)(i) above is identified in the Ordinance as the "Health Access Program." However, DPH has determined that the name "Health Access Program" creates confusion

among San Francisco residents because of its similarity to other programs. Accordingly, the program shall be named "Healthy San Francisco," and is hereinafter referred to in these regulations as "Healthy San Francisco."

(c) The Healthy San Francisco program will be among those programs offered in satisfaction of the City and County of San Francisco's obligation to provide services to indigent persons under California Welfare and Institutions Code Section 17000. The Regulations in no way shall be construed as an expansion of the City and County of San Francisco's existing obligations to provide health care under any California and/or federal law. Nor shall the regulations limit an individual's entitlement to those services otherwise required under California law.

2. Definitions

(a) *Applicant.* Any person who applies to participate in the Healthy San Francisco program or the Medical Reimbursement Account program.

(b) *Application.* The form developed by DPH to determine applicant eligibility for Healthy San Francisco.

(c) *City.* The City and County of San Francisco.

(d) *Clinical Site or Clinical Setting.* Any licensed facility that provides health services.

(e) *Covered Employee.* Any person that meets the definition provided in Section 14.1(b)(2) of the Administrative Code and Regulation 3 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(f) *Covered Employer.* An employer that meets the definition as set forth in Section 14.1(b)(3) and its inclusive subparts of the Administrative Code and Regulation 2 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(g) *Federal Poverty Level.* Level determined by the "Poverty Guidelines for the 48 Contiguous States and the District of Columbia" as contained in the *Annual Update of the HHS Poverty Guidelines* developed by the United States Department of Health and Human Services as published in the Federal Register.

(h) *Healthy San Francisco Participant.* Any uninsured San Francisco resident who fulfills all Healthy San Francisco eligibility provisions and is enrolled in the program.

(i) *Health Services.* Those services provided through the Healthy San Francisco program which a Participant will receive to treat a health or medical condition, promote health and/or prevent disease.

(j) *Household Income.* The total annual income of all family members in a household.

(k) *Medical Home.* The clinical site or clinical setting in which a Participant receives preventive and primary care services.

(l) *Medical Reimbursement Account.* An account established and maintained by DPH or its vendor from which eligible individuals may receive reimbursement for out-of-pocket medical expenses.

(m) *Ordinance.* The San Francisco Health Care Security Ordinance adopted by San Francisco Board of Supervisors as Ordinance 218-06, inclusive of any future and subsequent amendments.

(n) *Participation Fee:* A quarterly amount that Participants in Healthy San Francisco must pay to remain eligible for care under the program.

(o) *Point-of-Service Fees:* The amount(s) a Participant must pay for specific services at the time services are obtained.

(p) *Provider:* A California licensed health plan, hospital, clinic, medical group or clinician contracted to deliver health services to program Participants.

(q) *Third-Party Administrator.* A vendor or other entity that DPH enters into a contract with to perform specified administrative functions on behalf of the program.

3. Healthy San Francisco Program Eligibility

(a) An eligible Participant is any person who:

(i) resides in San Francisco and provides documentation of San Francisco residency based on the guidelines stated in the Healthy San Francisco program brochure provided to applicants;

(ii) is between the ages of 18 and 64 years old, or is an emancipated minor, or a minor not living in the home of a birth or adoptive parent, a legal guardian, caretaker relative, foster parent, or stepparent, and is applying for coverage on his or her own behalf;

(iii) has been without employer-based or individually-purchased health insurance for 90 days from the date of application for Healthy San Francisco eligibility, or has lost employer-based health care coverage within 90 days of date of application due to a change in employment status, or who has lost COBRA coverage within 90 days of date of application; and

(iv) is ineligible for California and/or federally-funded health insurance or assistance programs, provided that the applicant's eligibility for the following programs shall not make the applicant ineligible for Healthy San Francisco:

1) Pregnancy-Related Medi-Cal (Omnibus Budget Reconciliation Act);

2) Pregnancy-Related Medi-Cal (Presumptive Eligibility);

3) AIM Access for Infants and Mothers and

4) Omnibus Budget Reconciliation Act Medi-Cal (non-pregnancy and emergency only).

(b) Neither employment status, immigration status nor the existence of pre-existing health conditions shall be used to exclude a person from eligibility for Healthy San Francisco.

(c) DPH will develop an application for participation in Healthy San Francisco and a process for obtaining a Medical Reimbursement Account for potential participants.

(d) The Healthy San Francisco application will collect information from the applicant necessary to determine program eligibility and eligibility for any subsidies for participation in the program, including, but not limited to name, address, household income, and employment status.

(e) An eligible Participant shall be enrolled for participation into the Healthy San Francisco program if he/she submits a completed application, fulfills the eligibility requirements and pays the required participation fees as established by DPH.

(f) DPH shall, from time to time, require participants to re-establish eligibility for participation in Healthy San Francisco.

4. Healthy San Francisco Program Fees

(a) Healthy San Francisco will have two fee components for its Participants; "participation fees" and "point-of-service fees." These fees shall be based on Participant income which is measured with reference to the Federal Poverty Level.

(i) Participation fees shall be assessed on a quarterly basis for continued participation in the Healthy San Francisco program.

(ii) Point-of-service fees shall be assessed on a sliding scale based on a Participant's Federal Poverty Level when a Participant receives services at a clinical site or clinical setting.

(iii) Any person with an annual household income between 0% and 500% of the Federal Poverty Level shall be eligible for a subsidy for the participation fee, to be determined by DPH.

(b) Non-payment of the participation fee by the program Participant can result in cancellation of enrollment from the Healthy San Francisco program.

5. Healthy San Francisco Services

(a) The program shall provide health services for the treatment of medical conditions with an emphasis on wellness, preventive, and primary care. Services include: professional services by clinicians

(i.e., doctors, nurse practitioners, physician assistants, and other licensed health care providers) including preventive, primary, diagnostic, and specialty services; inpatient and outpatient hospital services; diagnostic and laboratory services, including therapeutic radiological services; behavioral health services, including mental health and substance abuse services; prescription drugs, excluding drugs for excluded services; home health care; urgent care; and emergency care provided in San Francisco.

(b) The following is a non-exclusive list of services that shall not be provided by Healthy San Francisco program:

(i) Acupuncture;

(ii) Allergy Testing and Injections;

(iii) Audiology (including hearing aids);

(iv) Chiropractic;

(v) Cosmetic;

(vi) Dental;

(vii) Gastric By-Pass Surgery and Services;

(viii) Genetic Testing and Counseling;

(ix) Infertility;

(x) Long-Term Care;

(xi) Organ Transplants;

(xii) Sexual Reassignment Surgery;

(xiii) Transportation: Non-emergency; and

(xiv) Vision.

(c) Healthy San Francisco does not include any services, including emergency services, provided outside the City and County of San Francisco.

6. Healthy San Francisco Service Provision and Delivery Network

(a) Each Participant shall have a designated clinical site or clinical setting that shall serve as his/her primary care medical home. The primary care medical home shall coordinate a Participant's access to services in the program, monitor management of medical conditions and provide continuity of care.

(i) Upon enrollment into the program, Participants shall select their primary care medical home from a list of participating Healthy San Francisco clinic sites or clinical settings.

(ii) Participants may request a medical home change during their pre-determined program recertification and re-enrollment process.

(iii) Participants may make requests to change their primary care provider (i.e., a physician, nurse practitioner or physician assistant) within their medical home.

(b) The network of providers delivering services to program Participants shall be confined to licensed providers who have a physical location and practice in the City and who have entered into agreements and/or contracts with DPH and/or its Third-Party Administrator to provide services under this program.

(c) Healthy San Francisco shall not include or reimburse payment for services delivered to program Participants by providers that have not entered into agreements and/or contracts with DPH and/or its Third-Party Administrator to provide services to Participants under this program.

7. Covered Employee Participation Rules

(a) Covered Employers who chose to satisfy the Employer Spending Requirement under the Ordinance by making payments to the City shall deliver the payments to DPH's Third Party Administrator. Payments shall be made consistent with the provisions of Section 14.3(a) of the Administrative Code and Regulation 6 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(b) Along with its payments, the Covered Employer shall provide to DPH's Third-Party Administrator: (i) the name of the Covered Employee, (ii) the amount paid per Covered Employee and (iii) other information as needed by DPH to determine whether the Covered Employee is eligible for participation in

Healthy San Francisco or for the establishment of a Medical Reimbursement Account. DPH or its Third-Party Administrator shall provide Covered Employers with a form upon which they may provide this information along with their payments.

(c) DPH's Third-Party Administrator will use the information provided by the Covered Employer pursuant to subsection 7(b) above to determine whether the payment made on behalf of a Covered Employee shall be used to fund the Covered Employee's participation in Healthy San Francisco or to establish a Medical Reimbursement Account for the Covered Employee.

(d) Covered Employees on whose behalf a payment has been made to satisfy the Employer Spending Requirement shall be notified by their Covered Employer that such a payment has been made in accordance with Regulation 7.1 of the Office of Labor Standards and Enforcement's Regulations Implementing the Employer Spending Requirement of the San Francisco Health Care Security Ordinance.

(e) DPH or its Third-Party Administrator shall inform Covered Employees where they may go to be screened for enrollment in Healthy San Francisco and/or establishment of Medical Reimbursement Accounts.

(f) A Covered Employee on whose behalf payment has been made to DPH must, in order to participate in Healthy San Francisco, meet program

eligibility requirements and enroll in Healthy San Francisco.

(i) A Covered Employee who is determined to be eligible for Healthy San Francisco shall receive a discount of 75% off the participation fee that s/he would otherwise be required to pay to participate in Healthy San Francisco. If as a result of the discount the fee is less than $50 per quarter, the participation fee shall be waived.

(ii) Payments by the Covered Employer shall entitle the Covered Employee to a discounted Participation Fee for six months from the date of enrollment. After six months from the date of enrollment, and every six months thereafter, DPH or its Third-Party Administrator shall determine whether the Participant's Covered Employer has continued payments on the Participant's behalf in the preceding six months. If the Covered Employer has continued to make such payments, the Participant shall remain eligible for a discounted Participation Fee for the following six months. If DPH or its Third-Party Administrator determines that the Covered Employer has not made payments on the Participant's behalf for the preceding six months, the Participant may remain enrolled in Healthy San Francisco by paying a non-discounted Participation Fee.

(g) A Covered Employee that does not meet the program eligibility requirements for participation in Healthy San Francisco but wishes to benefit from the payment made on his/her behalf by a Covered Employer, may sign up for a Medical Reimbursement Account to be established and maintained by DPH's Third Party Administrator. Any funds collected on behalf of a Covered Employee during the calendar year shall be forfeited if the Covered Employee does not sign up for a Medical Reimbursement Account by July 1 of the subsequent calendar year. Any forfeited funds shall be used by DPH to fund the programs described in these regulations.

(i) Covered Employees may obtain reimbursement from the Medical Reimbursement Account for medical care, services or goods that may qualify as tax deductible medical expenses under Section 213 of the Internal Revenue Code including the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body, including the costs of equipment, supplies and diagnostic devices needed for these purposes. Reimbursable medical expenses may also include dental expenses, premiums paid for insurance that covers the expenses of medical care and the amount paid for transportation to receive medical care.

(ii) Any administrative fees charged to the City to establish and maintain the Covered Employee's Medical Reimbursement Account shall be deducted from the balance amount in that Covered Employee's Medical Reimbursement Account.

(iii) A Covered Employee must use the money deposited into the Medical Reimbursement Account within a designated period of time as determined by DPH.

8. Public Information on Healthy San Francisco

(a) DPH shall make available to the public all information necessary to facilitate participation in the programs authorized by the Ordinance.

(b) Written program materials for applicants and participants will be offered, at a minimum in the following languages: Chinese, English and Spanish.

(c) DPH will maintain a program website and ensure that access to program information is available through the 311 System operated by the City.

9. Healthy San Francisco Administration

(a) DPH is responsible for the overall administration of the Healthy San Francisco and Medical Reimbursement Account programs. Its responsibilities include, but are not limited to: overseeing overall

program development and implementation; defining program goals, design and policy objectives; ensuring adequate financing and evaluating the program's effectiveness.

(b) DPH may enter into a vendor/contract relationship with a Third-Party Administrator and/or other entities to perform specific administrative or programmatic functions needed to appropriately operate and maintain the program.

10. Reporting

(a) DPH shall make annual reports to the San Francisco Health Commission on the status of the Healthy San Francisco and Medical Reimbursement Account programs.

(b) DPH shall comply with Section 14.4(f) of the Administrative Code with respect to Healthy San Francisco and Medical Reimbursement Account program reports to the San Francisco Board of Supervisors.

APPENDIX C

DENNIS J. HERRERA, State Bar #139669
City Attorney
WAYNE SNODGRASS, State Bar #148137
VINCE CHHABRIA, State Bar #208557
Deputy City Attorneys
City Hall, Room 234
1 Dr. Carlton B. Goodlett Place
San Francisco, California 94102-4682
Telephone: (415) 554-4674
Facsimile: (415) 554-4747
E-Mail: vince.chhabria@sfgov.org

JEFFREY LEWIS, State Bar #66587
LEWIS, FEINBERG, LEE, RENAKER
& JACKSON, P.C.
1330 Broadway, Suite 1800
Oakland, CA 94612
Telephone: (510) 839-6824
Facsimile: (510) 839-7839
E-Mail: jlewis@lewisfeinberg.com

Attorneys for Defendant
CITY AND COUNTY OF SAN FRANCISCO

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

GOLDEN GATE RESTAURANT ASSOCIATION, an incorporated non-profit trade association,

Plaintiff,

v.

CITY AND COUNTY OF SAN FRANCISCO and Does 1 through 15, inclusive,

Defendants,

and

SAN FRANCISCO CENTRAL LABOR COUNCIL, SERVICE EMPLOYEES INTERNATIONAL UNION ("SEIU") LOCAL 1021, SEIU UNITED HEALTHCARE WORKERS – WEST, and UNITE-HERE!, LOCAL 2,

Intervenors.

Case No. C06-6997 JSW

SAN FRANCISCO'S MEMORANDUM IN OPPOSITION TO GGRA'S MOTION FOR SUMMARY JUDGMENT

Hearing
Date: August 31, 2007
Time: 9:00 a.m.
Place: Courtroom 2
17th Floor

(Filed Aug. 3, 2007)

* * *

[9] GGRA appears to contend that any time a state or local government requires an employer to keep records of its health care expenditures, this runs afoul of ERISA. *See* GGRA's Memorandum of Points

and Authorities ("GGRA's Opening Brief") at 15-16. For this proposition GGRA cites *Aloha Airlines, Inc. v. Ahue,* 12 F.3d 1498, 1505 (9th Cir. 1993), in which the Ninth Circuit struck down a law that imposed reporting requirements on *a plan.* But again, GGRA fails to recognize that there is a distinction between imposing recordkeeping requirements on *an employer,* which is what the HCSO does, and imposing recordkeeping requirements on *an ERISA plan.* As the Ninth Circuit explained in *WSB* (a case not cited by GGRA in its opening brief), this distinction is significant. Although California's prevailing wage law required employers to keep track of benefit expenditures for employees on an hourly basis, this was an *employer payroll practice,* not a matter of ERISA plan administration. Because the recordkeeping requirements were imposed on employers, the law was not preempted. *WSB,* 88 F.3d at 793.[4]

---

[4] An example of the distinction between employer payroll practices and ERISA plan administration practices is provided by GGRA itself. GGRA offers information about the plans offered by Max's Restaurants for the purpose of establishing standing. *See generally* Declaration of Gregory Boro in Support of GGRA's Motion for Summary Judgment. Although the City does not contest GGRA's standing, Max's plan documents provide an illustration of how the recordkeeping provisions of the Ordinance operate without interfering with uniform plan administration.

Max's provides health benefits to some of its employees through Kaiser and HealthNet HMOs. *See* Declaration of Vince Chhabria in Opposition to GGRA's Motion for Summary Judgment ("Chhabria Decl."), Exh. A-B. As the documents for

(Continued on following page)

Furthermore, the employer is already in possession of the minimal information necessary to establish compliance. As discussed above, the employer need only determine: (1) the hours worked by its covered employees; and (2) how much it spent on those employees. With respect to the first [10] item, numerous laws already require the employer to track hours worked, including California Labor Code section 226. Moreover, employers must already maintain records of hours worked by their San Francisco employees, as set forth in the City's Sick Leave Ordinance. *See* S.F. Admin. Code § 12W.6.[5] With respect to the second item, tracking the information

---

those plans demonstrate, Max's has delegated virtually all aspects of plan administration to the HMOs themselves. The HMOs create the plan documents, process enrollment requests, create procedures for patients to file claims for benefits, and administer those claims procedures. *See, e.g.*, Chhabria Decl. Exh. A at 21, 30, 36, 42-43, 120-22, 133; Exh. B at 13, 17, 29, 40, 65-66, 72, 77-79. But the HCSO does not require the HMOs to keep records of any of these functions. Rather, it requires "covered employer[s]" to maintain records sufficient to demonstrate compliance with the Ordinance and to provide an annual report to the City. S.F. Admin. Code § 14.3(b). As even Mr. Boro admits in his declaration, it is "the company," not the HMOs, that will prepare the records necessary to establish compliance with the Ordinance. Boro Decl. at ¶ 8.

In any event, as demonstrated by the prevailing wage cases, even if an employer administers its own plan, laws like the HCSO impose recordkeeping obligations on the employer *qua* employer, not the employer *qua* plan administrator.

[5] As the documents submitted by Max's Restaurants demonstrate, it already keeps track of hours worked. *See* Chhabria Decl., Exh. C.

is even easier. For example, Max's Restaurants receives a bill every month from the HMOs which sets forth the amount due for *each individual employee.* Chhabria Decl., Exhs. D-E. With these two items of information, the employer need only divide item two by item one – i.e., the amount spent on health care for an employee by the number of hours worked by that employee – to establish compliance.[6]

In sum, employers commonly must engage in different payroll practices in different jurisdictions. As the prevailing wage cases already demonstrate, sometimes those payroll practices relate to health benefits. And in San Francisco, with the enactment of the HCSO, one of those payroll practices is the simple act of division described above. The Ordinance does not require ERISA plans to keep any records, nor does it require ERISA plans to report any information to the City. It requires employers to do so, and the

---

[6] In fact, for employers that provide uniform health benefits to groups of employees, establishing compliance will be even easier than the simple calculation described above. Those employers can simply divide their total employee health care expenditures by the total number of hours their covered employees have worked, and if that calculation demonstrates that the employer is spending, on average, more than the minimum required amount per employee, compliance has been established. RJN Exh. B (OLSE Reg. No. 6.2(B)(1)). Based on Max's own description of its ERISA plans, *see* Boro Decl. at ¶¶ 5-7, it appears Max's could avail itself of this shortcut.

Ninth Circuit has made clear that this creates no preemption problem.[7]

C. The Enforcement Provisions Do Not Interfere With Uniform Plan Administration.

GGRA also contends the IICSO is preempted because it creates "an enforcement scheme beyond that provided by ERISA." GGRA Opening Brief at 16. Specifically, GGRA asserts that the provisions of the Ordinance that permit the Office of Labor Standards Enforcement ("OLSE") to

* * *

---

[7] Furthermore, as discussed in the City's Opening Brief, even if the Ordinance were to impose these administrative burdens on ERISA plans as opposed to employers, the Supreme Court has upheld laws of general applicability that impose administrative burdens far more onerous than this one on ERISA plans. City's Opening Brief at 23; *Mackey v. Lanier Collection Agency & Service*, 486 U.S. 825, 831 (1988).

APPENDIX D

Amendment of the whole
in committee. 7/17/06

FILE NO. 051919 ORDINANCE NO. 218-06

[San Francisco Health Care Security Ordinance]

Ordinance amending the San Francisco Administrative Code to add Chapter 14, Sections 14.1 through 14.8, to provide health care security for San Francisco residents by creating a public health access program for the uninsured, requiring employer paid health expenditures, identifying options for how an employer may make such expenditures, creating an advisory health access working group, and setting an operative date.

Note: Additions are *single-underline italics Times New Raman*;
deletions are ~~*strikethrough italics Times New Roman*~~.
Board amendment additions are double underlined.
Board amendment deletions are ~~strike-through normal~~.

Be it ordained by the People of the City and County of San Francisco;

Section 1. **Declaration of legislative findings and intent.** All San Francisco residents should have quality, affordable health care. Currently, approximately 82,000 adult San Francisco residents are uninsured, even though more than half of those

individuals are employed. San Francisco taxpayers bear the cost of paying for emergency room visits and other unnecessarily expensive health care for the uninsured. By establishing a Health Access Program for uninsured San Francisco residents with an emphasis on preventive care and by requiring businesses' to make reasonable health care expenditures on behalf of their employees depending on the businesses ability to pay, the burden on San Francisco taxpayers for providing health care for the uninsured can be reduced. At the same time, San Francisco can offer uninsured individuals the choice to enroll in a system that provides quality health care for an affordable price and offer employers the choice to enroll their employees in that system. San Francisco also has a vital interest in preventing a "race to the bottom" in which employers stop paying for employee health care to remain competitive and instead shift those costs to San Francisco taxpayers.

* * *